HEALTH & DESEASE — GENERAL

1987 — 1988

Masa head reacts to call to shun SA Medics

By Jo-Anne Collinge

The Medical Association of South Africa (Masa) has reacted sharply to the Harare Conference proposals for action to isolate doctors who collaborate in the repression of children and who fail to associate with the struggle for non-racial government.

Conference statements concerning the South African medical profession were "unsubstantiated and merely repeat specious innuendo regularly directed at the profession with no specificity either as to incident or individual," said Dr Jonathan Gluckman, spokesman for the Southern Transvaal branch of Masa.

One recommendation at the conference, attended by 650 people from South Africa, international anti-apartheid organisations and the African National Congress, proposed that "alternative" professional organisations committed to a democratic South Africa be supported internationally and al others be expelled from world bodies.

Another said doctors who treated children after abuse in detention and remained silent should be struck off the professional register.

"The detention of children is ever deplored and ill-treatment or torture condemned absolutely," said Dr Gluckman. "We are members of the World Medical Association and adhere resolutely to the declarations of Havana and Tokyo."

He said a code, motivated by Masa, relating to the treatment of children in detention had been produced by the South African Paediatric Association and had been accepted by the relevant Government departments.

"Presumably the Harare Conference's reference to 'alternative' professional organisations alludes to a small medico-political body here whose prime efforts seem more to be directed towards the undermining of the medical profession in South Africa than the promotion of health and welfare."

MASA request turned down

Pretoria Correspondent

A request to hold medical disciplinary hearings in camera because of "unfair media publicity" has been turned down.

The South African Medical and Dental Council (SAMDC) confirmed a resolution of earlier this year by its executive committee that disciplinary hearings should continue to be held in public.

The request, by the Medical Association of South Africa (MASA), follows a complaint by one of its members who had been sentenced by a SAMDC disciplinary committee. The member claimed his practice had been negatively affected because of inaccurate press reports.

"To avoid unsavoury publicity of this nature, investigations by disciplinary committees should be held in camera and details should only be made known when the recommended sentence is confirmed by the full SAMCD council," the MASA letter said.

MASA pointed out that although this recommendation had been accepted by the SAMDC in October 1982, it had later been denied by the then Minister of Health and Welfare.

The Minister had said that in camera inquiries should be held only "where the prejudice to the accused through a public hearing was regarded more important than the right of the community to have first-hand knowledge of the enquiry".

MASA's executive committee of the Federal Council informed the SAMDC in their letter that it intended bringing the matter of problems resulting from media publicity of disciplinary committee findings, to the attention of the Minister of National Health and Population Development, Dr Willie van Niekerk.

The SAMDC also confirmed a resolution that the use of a veterinary drug in the emergency treatment of humans, although of value, was not permissable.

Thiotic acid — recommended for mushroom poisoning in a poisoning management guide published by the Natal Provincial Administration's department of Health Services — and found in the product Tioctan Vet, was "registered as a drug for veterinary use only."

Council members confirmed the resolution that the Registrar of Medicines be advised to consider reclassifying the drug for human usage, while the SAMDC president, Professor Frans Geldenhuys, said the Veterinary Council had requested a meeting to discuss the matter.

Privatising health

Privatisation of health care services has come a step closer through the initiative of two enterprising local businessmen. Prime beneficiaries of the cheaper services to be offered shortly will be SA's black population.

While the principle of privatising health care has government sanction, actual implementation of the programme has lagged. Which is why the two proponents of privatisation decided to wrest the initiative and go it alone.

Don Sutherland and Brian O'Donnell, men with vast experience in the health care business, recently formed a new company, Community Clinics. They plan to open the first of a series of clinics where black employees can receive full medical treatment — including all drugs and medications — for R15 a month.

Heavily involved

Both have been heavily involved in investigations into health service privatisation. Sutherland, past president of the Pharmaceutical Society, has served on four major pharmacy and health care investigations since 1980 and assisted in submitting a document to the Cabinet on health care privatisation. O'Donnell is a former MD of SA Druggists and a member of the pharmaceutical sub-committee of the Browne Commission investigating health services in SA.

Says Sutherland: "It is clear the taxpayer cannot carry the burden of health care much longer. At the moment the state provides 65% of all medical services at 32% of the actual cost. More privatisation is desperately required, particularly in the black area, which is one of the major health care issues of the future.

"It is all very well saying privatise and put them on medical aid schemes. But where do they get their services? Where are the hospitals and clinics in Soweto and Alexandra and all the other black urban areas?

"Research indicates that urbanisation of blacks will increase from 37% today to 65% by the year 2000. SA is faced with the prospect of its health services being incapable of supporting the demands being made on it."

Part of the answer, they believe, could lie in their clinics for black company employees and private individuals. "Initially we hope to convince employers in industry to put their workers into the scheme. Then we will interest employers of domestic workers to participate," says Sutherland. "Ultimately, we hope to create widespread interest among black urban residents."

First clinic

The first clinic, in the Kew/Wynberg/Bramley industrial complex bordering on Alexandra township, will open by month-end.

Sutherland says the scheme is simple. For R15 a month, a client will receive full medical treatment up to — but not including — hospitalisation.

"The emphasis is preventive rather than curative. It is a move away from First World medical structures towards an affordable, dignified but perhaps more utilitarian approach that is essentially nurse-based.

"We plan to offer on-site medical inspections for industries through a mobile health unit so that workers can be checked on a regular basis. We will work with a basic list of medicines which cover 95% of the illnesses we believe to be prevalent. If a medicine is not on the list, it cannot be prescribed. This is how we can offer a full service for such a low cost.

"We have also developed a database allowing us to monitor the utilisation rate of the clinic and the illnesses or injuries experienced by workers in a company. This we compare with average trends and if any irregularities show up, we can consult with management to improve the situation."

Sutherland and O'Donnell don't expect the scheme to be beyond criticism, but are confident they can provide a national chain of clinics offering the most cost-effective service possible.

Says Sutherland: "We've been waiting around too long for something to be done about health services and all that has happened so far is talk. We've gone out and devised a solution unique to SA, aimed at our specific problems." ■

One service 'in best interests of health'

Business Day Reporter

PRETORIA — The interests of national health might be better served by a single health service rather than the proliferation of health departments under the new dispensation with their ministers, deputy ministers, directors, deputy directors and others.

So said Johannesburg MOH Hilliard Hurwitz yesterday at the biennial congress of the Institute of Public Health.

In his presidential address he said health was indivisible and knew no boundaries of geography or population groups. It seemed one body was needed to effectively orchestrate "the reaching of the ultimate goal".

A single authority could delegate down the line in accordance with the policy of maximum devolution.

Many of SA's present challenges such as TB control still defied solution and several other challenges loomed, Hurwitz said.

AIDS had killed 57 South Africans to date. In many cases victims' lifestyles brought it about.

Cigarette smoking contributed directly to coronary heart disease which killed 3 000 South Africans annually.

The health of the non-smoker was also affected by the habit.

On unemployment, Hurwitz said between 350 000 and 500 000 young blacks came into the labour market every year, which meant 1 000 new jobs had to be created every day.

It was unreasonable to expect the economy to grow at a rate which would provide the needed jobs.

This laid emphasis on the need for the informal sector to grow in a climate of deregulation. In the process, some holy cows would have to be sacrificed.

Hurwitz said certain aspects of patient care could be privatised. Some who claimed to offer community health services did not have the faintest idea of what was involved.

A problem of 'maldistrilution' as . .

SA also faces over-supply of health workers

GERALD REILLY

PRETORIA — The world-wide trend of an over-production of health manpower has become apparent in SA, Stellenbosch University professor Wynand Dreyer said yesterday.

He told the International Dental Congress in Pretoria the threat of an over-supply of health manpower had to be given timeous attention.

Over-production was causing world-wide concern. By the year 2000, it was estimated the world would face a surplus of more than 250 000 physicians.

Similar trends were developing for dental manpower, both in the developed and developing countries. In SA, however, it was not simply a matter of over-production of health personnel but rather one of maldistribution.

Urban communities were well supplied, while rural and deprived peri-urban communities had extensive nees. The trend towards maldistribuon would affect dentistry.

hile opening the congress, Napnal Health Minster Willie van Nieerk said some delegates had bee under substantial pressure not to tend the congress.

Iternational dental companies wei also present, in spite of the disinvitment campaign against SA.

Isinvestment, he said, could only han the health services of especially theeveloping people of SA who were larly dependent on State services.

Vn Niekerk said he was pleased "miningless" sanctions against SA hadot marred the liaison between SA ntists and dentists in other countrie

A the beginning of the year, 3 367 densts, 103 dental therapists and 448 orahygienists were registered with the A Medical and Dental Council.

SA health services could 'go private'

Pretoria Correspondent

The private sector could take over the running of hospitals and health services in South Africa.

In a statement yesterday, the Minister in the Office of the State President entrusted with Administration and Broadcasting Services, Mr Alwyn Schlebusch, announced that the Government had appointed Dr W J de Villiers to investigate and report on privatisation of hospital services in respect of cost effectiveness.

Dr de Villiers will be assisted by several experts and will consult with the sub-committee on privatisation of the Advisory Committee in which the private sector is represented before presenting his recommendations on hospitals and health services.

Mr Schlebusch said Government spending on hospitals and health was a source of great concern. The State could not carry the burden on its own.

"It must be determined in what manner the private sector's involvement in rendering health service can be further increased in order to limit the State's share and involvement to that which is essential."

Mr Schlebusch emphasised that the Government was embarking on the investigation without preconceived ideas.

New govt inquiry into health services angers experts

THE State's announcement of yet another "sweeping investigation" into hospitals and health services has come under heavy fire from both the Medical Associaton of South Africa (MASA) and the Pharmaceutical Society of South Africa (PSSA).

Dr John Cooke, the president of the Natal Coastal branch of MASA, said there was enough information available

Own Correspondent

from previous investigations for the Government to act on.

He said the new investigation was "just a delaying tactic to save any outlay".

"Everybody is simply getting sick to death of these endless commissions and of nothing being done," Cooke said.

He said there was crisis situation in respect of health services which could collapse if urgent action was not taken.

In light of this the new commission was "absolutely pathetic".

He said that last Friday, MASA had made recommendations to the State on possible action in respect of medical aid and other aspects of health services, but that it had refused to act upon them in any way.

"MASA motivated a whole host of ideas, all of which have been thrown out."

George Atkinson, chairman of PSSA said he failed to understand why the State had commissioned another investigation into the cost of pharmaceutical and health services when it had failed to act on the recommendations contained in other investigations including the findings of the recent Brown Committee.

Public health standards are dropping - SAIRR

EVENTS during the third quarter of 1987 have suggested that public health standards for all races are dropping because financing public health is a low government priority.

This finding highlighted in the latest *Social and Economic Update*, a quarterly review of social and economic conditions in South Africa.

Published by the South African Institute of Race Relations, *Update* says that the government is continuing to promote the privatisation of health services wherever possible and appears also to be pursuing a policy of privatisation by default. Because it is limiting the resources of public hospitals, staff are leaving these hospitals for private institutions.

The Institute says that this policy affects racial access to health care because far more whites than blacks can afford private medical care.

"The key measure of access to private care is the availability of medical aid: most patients who use private medicine are able to do so only because they enjoy medical aid cover.

"But very few black people have access to medical aid and if, as seems likely, the trend towards private care continues to grow, so will disparities between white and black health care."

Fewer than 30 percent of Indian and coloured people were covered by medical aid schemes in 1984, according to a study by University of Cape Town researchers. Earlier this year the Institute reported that fewer than 4 percent of blacks but more than 80 percent of whites were covered by medical aid schemes.

The Institute says that it is unclear as to how the Government will implement its policy that no one will be denied adequate health care because they cannot afford it.

Update notes that if the Government did decide to devote most of its spending to black health care, the segregation of facilities in medical institutions would be a constraint on the effective use of its resources.

Using existing, but under-utilised, white facilities could mean that black health needs would be cheaper than extending existing black hospitals or building new ones.

It is pointed out that the Government invested capital to provide for white facilities which are now unused and is still repaying the capital costs although it no longer receives any income from them.

Turning to the bed occupancy rate, *Update* quotes Dr Eric Buch of the Centre for the Study of Health Policy at the University of the Witwatersrand, who has found that 24 hospitals in the homelands had bed occupancy rates in 1985 which were greater than 100 percent. Patients were forced to share beds or sleep on the floor.

In 1986, the Gazankulu health service had a bed occupancy rate of 110 percent. Dr Buch estimates that black hospitals "have less than half (the beds) available for their white counterparts".

The publication also quotes Mr Daan Kirstein, member of the Transvaal Executive Committee responsible for health services, as saying that the bed occupancy rate at Baragwanath Hospital in Soweto in 1986/87 was 111,5 percent.

Turning to the provision of mental health care facilities, the Institute quotes Mr Lage Vitus, director of the National Council for Mental Health, as saying that only between 6 percent and 7 percent of the needs of mentally handicapped black children are being met.

Govt spending is questioned

THE South African Institute of Race Relations has questioned whether increased Government spending on black facilities will generate sufficient momentum to sustain the required development to reach parity in facilites for all races.

In its review of social and economic conditions during the third quarter of 1987, the Institute argues that the Government will be unable to sustain the burden indefinitely without cutting into white spending. It notes that the Government strategy is based on the belief that present spending will generate self-sustaining development and that the need for its contribution will steadily decrease. Evidence in the past quarter suggests that this may not occur, it says.

Black housing provision is an example where development has been severely hampered by the affordability problem.

It has thus far benefited only the 20 percent of people who are in the upper income group, most of whom enjoy a State subsidy; developers believe that this market is now "drying up", the Institute says in its quarterly publication *Social and Economic Update*.

The total black housing shortage is estimated to be more than 1,1 million, including the "independent" and "non-independent" homelands. It notes that 11 020 hectares of land has been set aside by the Department of Development Planning for black housing needs. A total of 154 280 new houses could be built on this land.

The Institute says that the past quarter emphasised again that the Government regarded black housing as a priority. Significant quantities of land were being released and the sale of rented stock was enjoying priority.

New legislative changes were to be introduced to speed up housing delivery and freehold title was finally to become a reality.

Racial

But it emphasised that racial land zoning and limitations on black land in the urban areas would continue to be a problem. This was illustrated by continuing complaints from developers that suitable land remained scarce and by the dissatisfaction of the House of Representatives with the sitting of land allocated to it.

"Some political analysts suggest that the release of well-sited black land is now constrained further because white local authorities and members of Parliament fear that allocating suitable black land will prompt white right-wing resistance."

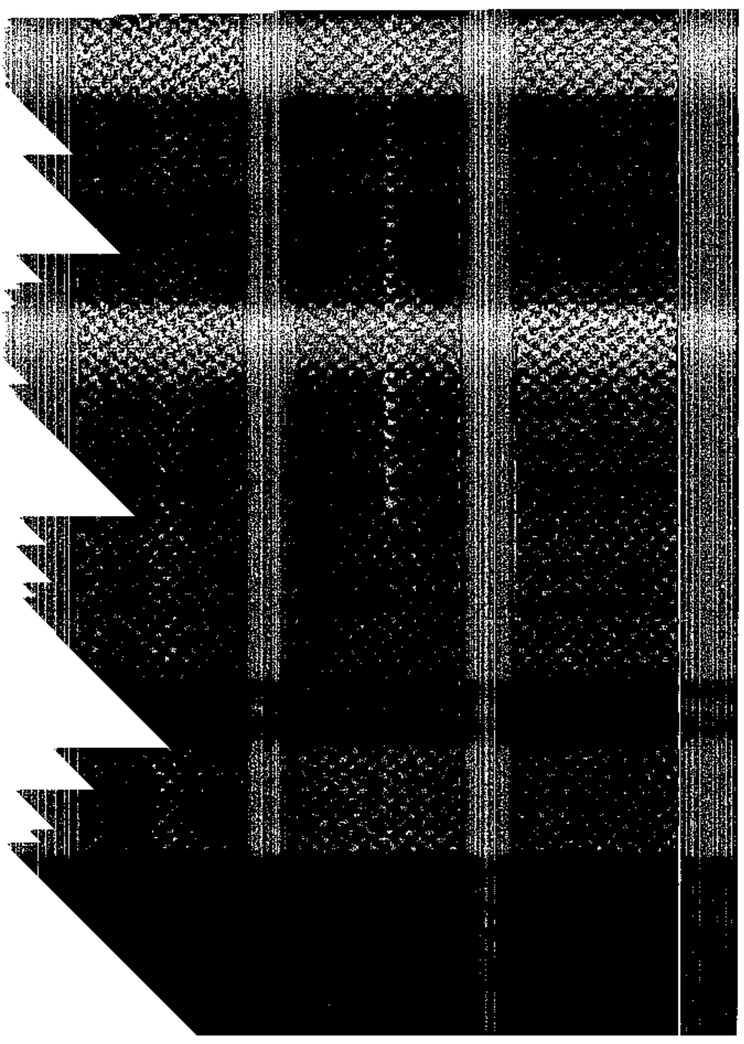
SAMDC accused of racialism

DURBAN — The South African Medical and Dental Council came under heavy fire at the National Peoples Party's Natal congress in Durban yesterday for refusing to recognise medical and dental degrees obtained by South Africans in India and Pakistan.

A resolution passed unanimously at the congress described the SAMDC's refusal as "blatant racialism" and urged the Government to investigate the statutory powers granted to the council.

It said the council sheltered in its promotion of racial discrimination behind these powers in the face of a frightening shortage of doctors and dentists especially in the Third World sector in the country.

It asked that the matter be taken up with the Minister of National Health and Population Development, Dr Willie van Niekerk — Sapa.



Patients wait for help outside a Lebowa clinic which is too short of space to provide a waiting room for them.

DROP IN HEALTH CARE STANDARDS

EVENTS during the third quarter of 1987 have suggested that the promotion of the privatisation of health facilities and the low priority given by government to public health have caused standards for all races to drop.

This is highlighted in the latest *Social and Economic Update*, a quarterly review of social and economic conditions in South Africa.

Published by the South African Institute of Race Relations, the update says the government is continuing to promote the privatisation of health services wherever possible and also appears to be pursuing a policy of "privatisation by default". Because public hospital resources are being limited, staff members are going into private institutions.

The institute says this policy affects access to health care on a racial basis because far more whites than blacks can afford private medical care.

"The key measure of access to private care is the availability of medical aid. Most patients who use private medicine are able to do so only because they enjoy medical aid cover. But very few black people have access to medical aid and if, as seems likely, the trend towards private care continues to grow, so will disparities between white and black health care."

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It is pointed out that the government invested money to provide for white facilities which are now unused. And it is still repaying costs although it no longer receives any income from these facilities.

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Turning to the provision of mental health care facilities, the institute quotes Lage Vitus, director of the National Council of Mental Health, as saying that only between six and seven percent of the needs of mentally handicapped African children are being met.

In an interview with a health worker, the institute found that there were often long waiting lists for psychiatric care among African people.

Meanwhile, in 1985 there was a 36 percent death rate among African children.

The comparative rate for whites was 12,5 percent, Indians 12,7 percent and 29,3 percent for coloured people. The coloured infant mortality rate in rural areas was 69,9 percent in 1984.

These figures reflect a marked decrease for coloured people and Indians when compared with the figures for 1981.

The African and white rates remained more or less the same. The institute found that most African and coloured infant deaths between 1981 and 1985 were caused by "factors associated with short gestation and infectious diseases".

(85) 22/11/87 C/Pwen

(85) SPM 26/11/87

Fact-finding group see what SA 'is really like'

Health-care system impresses Germans

By Toni Younghusband
Medical Reporter

The standards of South Africa's Third World health services were very high compared with other Third World countries — despite serious overcrowding in black hospitals, visiting German orthopaedic surgeon, Professor Gerald Pfluger, said at a press conference in Johannesburg yesterday.

Professor Pfluger has been in South Africa as part of a fact-finding mission from Germany to study South Africa's health-care system, provincial and private, and to "see what South Africa is really like".

The group of 42 doctors and businessmen arrived in South Africa on November 9. They visited Groote Schuur Hospital in Cape Town, Garankuwa Hospital near Pretoria, the Medical University of South Africa (Medunsa) and the Morningside Clinic in Sandton. The group also met leading specialist surgeons and medical experts.

Asked what he thought of overcrowding in black hospitals, Professor Pfluger said one had to be careful to compare Third World with Third World and First World with First World.

CREATED BAD IMPRESSION

Compared with other Third World countries the standards in South Africa's "Third World hospitals" were very high.

The group said German press reports had created a bad impression of the situation in South Africa, but now they had seen for themselves they were very impressed to see how this country was trying to uplift the health care of the black population.

Dr Michael Schreiber, a member of the Christian Social Alliance Party, said he had at first not wanted to visit this country.

"But now that I have seen what is happening here I believe that the present policy followed in South Africa is the correct policy to secure long-term advantages for the total population of this country."

Another member of the group, Mrs Gabriele Spitzmuller, said as a tourist of three weeks one could not see everything in a country but she was leaving the country with a different (favourable) impression and when she met the leader of Germany's Liberal Party in December, West German Foreign Minister Mr Hans-Dietrich Genscher, she would tell him to come to South Africa.

The group believed that semi-privatisation was the answer for South Africa's health services — a combined health service run by the Government and the private sector side by side and not competitively.

Nourishing healthy habits among kids

By GUGU KUNENE

THE plight of malnourished school children touched the heart of concerned women's organisations like the Women for Peaceful Change who then approached Fedfood in Johannesburg for help.

In 1981, the program of nutrition education was introduced in Soweto higher primary schools. But this ended abruptly because of the unrests.

In 1984, Van Den Bergh and Jurgens, a company which manufactures some of the most popular brands of margarine and edible oils, implemented the program in Natal schools. Schools running the program are the higher primary schools in Durban and surrounding areas, Maritzburg and Tongaat.

Acclaimed nutritionist Annette Makhanya, who is in charge of the whole program, said: "This program was introduced to children because most of them do not associate health with food but they eat because they are hungry."

The women felt the need to introduce the program to pupils since they spend more time with teachers than with parents during the day. This way, they would have more time to learn and absorb new ideas through repetition and experience.

This program entails training teachers to teach nutrition and during the training sessions certain teaching methods that were approved of by the Department of Education and Culture are recommended. The teachers use manuals which were written in conjunction with educational planners.

Pupils are then taught how to make vegetable gardens at school and at their homes using "the food gardens unlimited method" and inter-school gardening competitions are held annually. Pupils are also encouraged to bring healthy lunch boxes from home.

Makhanya said at the moment they were getting pressure from the lower primary teachers who also wanted the program to be implemented at their schools.

"Because of the lack of manpower, it is impossible to do so, though we do realise that it can be more effective because it will mean introducing the program at the grassroot level," explained Makhanya.

The objective of the program is to encourage each and every family to have a food garden at home. This can be possible because children have great influence on their parents and can actually help to change their family eating habits.

"Our duty is to motivate children because they are less set in their habits and are more acceptable to new ideas. This can sometimes prove to be a long-term process," said Makhanya.

To wrap it up, Makhanya said: "Our program is a 'hand up and not a hand out' one. In other words, our objectives are to ensure that pupils know what to eat and how this can affect their health, even their lifestyle."

(1) (85) C/Press 29/11/87

Call for 'peoples' health service'

THE National Council of Trade Unions yesterday reiterated its call for a national people's health service because of increased hospital charges.

In a statement to Sapa, Nactu said it deplored the increases in medical charges for treatment and medicine announced by the health authorities.

"When Finance Minister Barend du Plessis announced his budget we noted that the increase in the military and police expenditure was at the expense of basic social services which were so desperately needed due to the already inadequate services.

"Nactu reiterates its call for a national people's health service. Nactu believes that the unfair advantage and profiteering in medicine through the State tender system and all the abuses rampant in the system can only be eliminated if the system is open to the scrutiny of the people.

Chicken

"We further believe that the chicken run of doctors and other medical personnel should be curtailed by ensuring that such individuals are forced to work in State hospitals for at least four years before being allowed to leave the country. Taxpayers' money has subsidised their education and they should plough back into the community that which they have received from the community.

"Further, all doctors should be required to provide a minimum of five hours per week free service in state hospitals.

"Nactu wishes to warn all consumers in the country that 1988 will be a tough year for breadwinners to make ends meet." — Sapa.

'Rural population in SA is even worse off'

Homelands health spending under fire

SA CONTINUED to spend far too little on health care for its rural and homeland black population, Wits University's Centre for the Study of Health Policy director Dr Eric Buch said yesterday.

He said homelands' health systems remained inadequate and had not improved significantly over the past five years.

In addition, government voted considerably less money for the medical care of rural blacks than for urban populations, in spite of the greater health needs of the socio-economically deprived rural areas.

Buch painted a picture of poor health in the homelands -- adding that SA's non-homeland rural population was even worse off.

He said exact figures for the changes in the patterns of staffing and funding over the past five years were not available because the National Health Department did not issue these statistics.

However, he said SA was not spending enough money on health care in rural SA and the homelands, and poverty-related diseases continued to be widespread.

ROBIN TAYLOR

He said in addition to inadequate health services, socio-economic conditions in the homelands made inhabitants' health status unsatisfactory.

Surveys over the last five years had shown homeland infant mortality rates (IMR) between 36 and 130 per thousand children born, compared with 12 per thousand for whites. The IMR was a crucial indicator of health status.

"Diseases associated with poverty are widespread in the homelands. These include 6 291 notified cases of tuberculosis in 1986, 1 622 of typhoid and 2 676 of measles. One must also keep in mind that actual cases certainly significantly exceed notified cases," he said.

Childhood malnutrition was not notifiable, but was extensive. Cholera occurred widely in most homelands at some point in the 1980s, with a combined total of more than 20 000 cases.

"SA can easily afford to put substantially more money, more facilities and more staff into health care in homeland areas," he said.

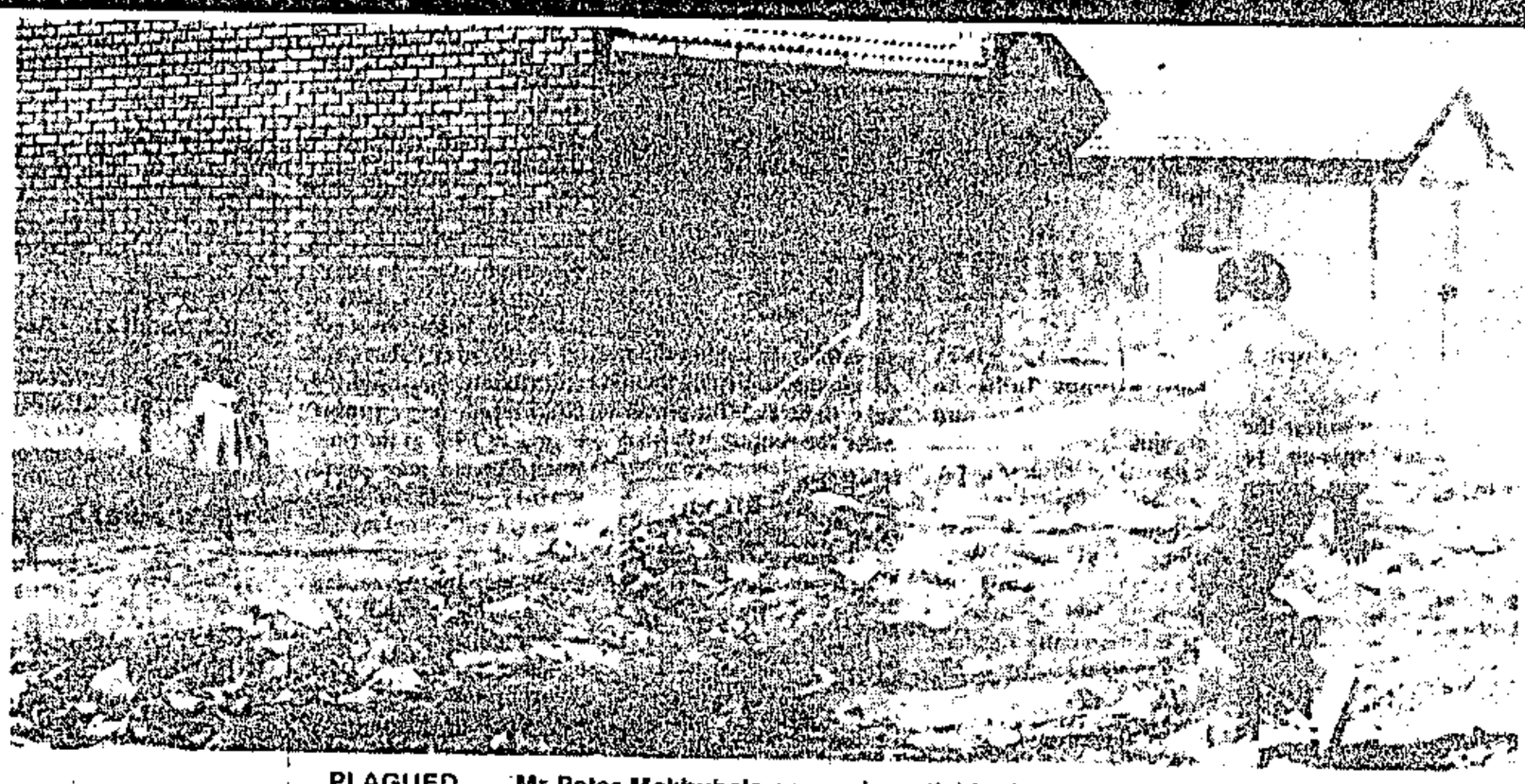
Homeland health budgets were substantially less than for white and urban South Africans. In 1984/5 only R400m of the total health budget of R3,2bn was allocated to the 42% of the population living in the homelands.

Buch said in 1985 24 homeland hospitals ran at greater than 100% occupancy, with patients sharing beds or sleeping on the floor. This did not happen in hospitals for whites.

"Most available funding goes into hospital services, but this is not to suggest that the hospitals are lavish. They have less than half of what is available for their white counterparts."

The doctor population ratio in homelands ranged from one to 10 000 to one to 40 000. The national average was one to 2 320, which was satisfactory by international standards.

BILHARZIA . . . Percy Mashaba.



PLAGUED . . . Mr Peter Makhubela sprays insecticide three times a day.

Disease in elite area 'a filth and no drains'

FLIES FLIES FLIES

THE new elite residential area in Mamelodi East, which comprises mostly professional people like teachers and nurses, is infested with flies and mosquitoes, and is now a health hazard, say residents.

The *Sowetan* has also established that a five-year-old boy was recently admitted to the Kalafong Hospital for five weeks after contracting bilharzia in the area known as "Mamelodi Gardens".

Residents interviewed by the *Sowetan* yesterday said they could not open their windows because of the "thousands of flies and mosquitos around".

Mr Peter Makhubela said they were "being plagued".

STENCH . . . Mr Johannes Moshaza.

Residents also complained that there were no drains, and that the roads were very bad: "These houses are flooded each time it rains heavily".

A woman who refused to have her name published for fear of reprisals said the dusty roads were filled with dongas and pools of stagnant water.

Houses built in the elite residential area vary in price between R30 000 and R100 000.

Stench

Residents also complained that the stench from the stagnant waters was unbearable, especially during the heat. Mr Makhubela said they hung fly-catchers in their homes to control the disease-carrying pests.

Mr J J Pienaar, Mamelodi's director of community services yesterday confirmed that the roads were bad, but said the matter was receiving attention. He added that the roads would be improved as soon as the developers finished building about 200 houses. Progress in improving the roads was retarded because of the large trucks that transported building material in the area, Mr Pienaar said.

Mr Makhubela said his uncle's five-year-old boy was recently admitted to the Kalafong Hospital after allegedly contracting bilharzia in the area. "This place is a health hazard. I regret having built here. It is not up to standard like the other elite areas," said Mr Makhubela, whose house is valued at R80 000.

Most residents said they sprayed their rooms with chemicals three times a day to kill the flies and mosquitos, "and now we must inhale the fumes as well," Mr Makhubela said.

Mwasa hit out at Bara

SAPA-AP

THE Media Workers Association of South Africa yesterday condemned "in the strongest terms" the decision taken by Baragwanath hospital and the Transvaal Provincial Administration to punish doctors responsible for an article in the SA Medical Journal which criticises conditions at the hospital.

"Mwasa condemns the decision to victimise doctors who were party to an article in the medical journal exposing the shocking conditions at Bara," a spokesman for the union said.

"Mwasa believes that the TPA and Bara should be proud to have on their staff doctors of such integrity and with such principles.

"These doctors have managed to uphold the ethics of their profession and have done this noble calling proud — they acted in the interests of their patients.

"It is undoubtedly only in this country that people are penalised for being dedicated to the care of their wards.

"We call on the community to support the doctors at Bara and other hospitals who work under such primitive conditions and we call on the authorities to reinstate those doctors already dismissed and improve the conditions at this hospital as a matter of urgency," the spokesman said.

85 Sunday Times 11/1/88

Mwasa to launch awareness project

THE Media Workers' Association of South Africa is to launch a media awareness training project for the public ....

Announcing the programme yesterday, Mwasa education co-ordinator and Transvaal regional chairman, Mr Sam Mabe, said monthly seminars would start in February.

He said the programme would be held in conjunction with other trade unions, student, youth, political and business organisations.

"The programme is aimed at helping the public... to know more about the media and the press in general," Mr Mabe said.

He said the monthly seminars would help the public in preparing press releases, conducting Press conferences, granting telephonic interviews, commenting on current issues, knowing what the media may or may not do under media regulations.

Newspaper deadlines, press language, policy and other related issues will also be covered.

The seminars are also designed to stimulate a "more critical reading and interpretation of news".

Circumventing media restrictions and involving the public in devising ways in which they could be informed despite the restrictions will also be discussed.

Unions and organisations wishing to participate may contact Mwasa's general secretary, Mr Sithembele Khala at (011) 29-5490 or write to PO Box 11136, Johannesburg 2000.

Refuse is a health hazard

Mr Yster Mashile, a Seshego (near Pietersburg) resident, in his driveway — partially blocked by a heap of refuse and a dead dog. Heaps of rubbish dumped recently on street corners in Seshego are becoming a health hazard to residents.

They have complained that refuse in bins is not being collected regularly and that people are simply dumping their waste anywhere.

"Something drastic must be done to stop this," said Mr Mashile.

Town management officials could not explain the delay by refuse vehicles to clear the streets but promised the problem would receive immediate attention.

Who lives, who dies who decides?

9/12/88

85

South Africa's economic situation was such that there was no reason why an acceptable standard of health care should not be made available to all its citizens, a theologian said in Johannesburg last week.

Professor Victor Bredenkamp, of the department of religious studies at the University of Natal, was addressing the health care symposium at the Unversity of the Witwatersrand which was attended and addressed by theologians, lawyers and health care workers.

"Our infrastructure is sufficiently developed to enable everyone to have relatively easy access to hospitals and clinics," Professor Bredenkamp said.

He said that any imbalance in the provision of health care was an offence against the Divine Will and that it was "common knowledge that there are not nearly enough medical resources for all those who need them".

"There are fewer kidney machines than there are people who need them. The resulting crucial dilemma is: who lives, who dies, and most important of all, who decides?"

He asked whether millions should be spent on organ transplants when the vast majority of people could not get adequate minimum health care.

He said that thousands of children died annually in South Africa from measles and other paediatric diseases due to an insufficiency, or total lack, of preventive medicine in their areas.

To illustrate the inequality of the provision of health care he referred to a recent annual report of the Department of Health and Welfare. According to this report only 21 percent of all legal abortions were carried out on black women — while the same group made up 78 percent of all admissions for incomplete abortions.

Professor Bredenkamp said the question was not so much whether adequate health care could be provided but whether "we have the neccessary determination to ensure that it is done".

Storey tilts at privatisation of health care

Sts 9/2/88

By Carina le Grange

The provision of health care is a matter of simple justice, not a privilege, the Reverend Peter Storey said in Johannesburg last week.

Mr Storey, a former president of the Methodist Church, addressed a multidisciplinary symposium on "Medicine and Health Care in South Africa" held at the University of the Witatersrand. The symposium was addressed by theologians, health care workers and lawyers.

Mr Storey referred in his address to the victimisation of the Baragwanath doctors who voiced their concern about conditions at the hospital and who faced disciplinary measures for doing so.

He said no doctor could, in good conscience, take the Hippocratic Oath without becoming a lifelong, active enemy of apartheid.

Saying health care was a human right and taking a strong stand against privatisation of health care, Mr Storey quoted British health service pioneer Mr Aneurin Bevan: "No society can call itself civilised if a sick person is denied medical aid because of a lack of means."

A POLITICAL PROBLEM

"In the context of South Africa, true justice in health care is impossible to attain without fundamental political change. Justice in health care is a political problem before it is a medical one."

He said there was hardly a more glaring example of the "immorality of reform" than that seen in health care.

"So-called reform consists in the deprived majority being served crumbs from the tables of the privileged minority. Accelerated reform means a more generous helping of crumbs but not an invitation to take a seat at the table.

"Consider the message communicated when a new hospital is built in Johannesburg — presumably because the old one (now Hillbrow Hospital) was hopelessly outdated. Blacks are told: 'You can have the old one now, it is no good to us any more'."

RACIAL SUPERIORITY

Mr Storey said that the shiny, half-empty, new Johannesburg Hospital contrasted sharply with the "overcrowded, dilapidated Baragwanath" and that a new hospital was planned for Pretoria while Mamelodi, with a larger population, had inadequate health care facilities.

"Each of these examples speaks of an official attitude blinded by an ideology of racial superiority, compounded by righteous indignation when proper gratitude for the crumbs is not forthcoming.

"To those who hound doctors whose simple concern for justice led them to protest against conditions at Baragwanath, Jesus would say: 'You hypocrites — focusing your wrath on a splinter of procedural indiscretion in these people when you should be taking the great plank of 300 years of gross discrimination out of you own eye. You strain at gnats and ignore camels.'

"Privatisation of health care will make it a matter of accounting instead of caring and I find it strange that a government so obsessed with controlling every area of our lives should want to abdicate at a point where they have real responsibility for those same lives," Mr Storey said.

Health services need money

Citizen 21/2/88

A shortage of money is hampering the growth of hospital services and is creating a shortage of ward space.

Special Correspondent

A SHORTAGE of money is the largest obstacle hampering hospital and health services in South Africa, Dr Willie van Niekerk, Minister of National Health and Population Development, told a Press conference in Cape Town recently.

Wards in many hospitals had been closed down and some had never been used, due to lack of money to pay the nursing staff needed to keep these wards operative, he said.

Furthermore, the high growth rate in the black population – causing a rapid-growing demand for medical care for patients – placed increasing demands on available hospital facilities.

The large patient-load on present facilities was a reason for concern, Van Niekerk said. He referred specifically to Baragwanath Hospital in Soweto, Welkom Hospital and King Edward Hospital in Durban.

The financing of patient treatment had become a worldwide problem, even in countries such as the United States and the United Kingdom. The real cost for a State-subsidised patient in South Africa varied between R100 and R150 a day, of which the patient paid only R2,00.

Van Niekerk, addressing more than 70 foreign and South African journalists gave a summary of the state of health services in South Africa, advancements made in the fight against contagious diseases, the general improvement of the level of health among all population groups and problems with health services in general.

Van Niekerk pointed out that the infant mortality rate had decreased among all population groups during the past 40 years and that endeavours were being made to decrease the rate even further, especially among blacks and coloureds. Another parameter for the general health level – life expectancy – increased among all population groups.

Special programs for innoculation and treatment kept the level of contagious diseases like diphtheria very low. Tuberculosis still remained a serious problem and R135-million would be spent in the next financial year on the innoculation of people and treatment of patients suffering from the disease.

With regard to the Baragwanath crisis, he said that should money be made available, wards with beds for at least 200 patients would be opened in Leratong and Hillbrow hospitals. Surveys had shown that about 75 percent of patients who reported to Barawagnath Hospital, could be treated at the various clinics in Soweto.

At least two new hospitals in Pretoria and Soweto, providing beds for about 2 000 black people, had already been planned.

Van Niekerk pointed out that health services in South Africa should be compared with countries where patients had comparable average incomes – Greece, Spain, Italy and Israel.

Expenditure on health services formed 5,4 percent of the country's annual budget. In the financial year 1985/86, a total of R6 176-million was spent on health services – 60 percent went to the public sector's 650 hospitals and 40 percent was spent by the private sector.

He said private-sector health services should be expanded and more blacks needed to join medical aid funds.

Van Niekerk highlighted malaria and Aids as two serious health problems:

● The growing occurance of malaria which resisted medication in the northern and north eastern areas of the country was a matter of great concern.

Factors contributing to this were the rainy season, the migration of Mozambicans to South Africa – a third of whom are carriers of the resistant malaria parasite, and a new type of mosquito with a very high frequency of biting.

● The South African government had entered into negotiations with the government of Malawi about the repatriation of about 1 000 aids-carrying Malawians, employed on South African mines.

Therapy can be good for growth says Wits prof

DIANA SHMUKLER: "More men going into therapy."

By Marika Sboros

The majority of patients who have psychotherapy are women and this is an international phenomenon, says Professor Diana Shmukler of the University of the Witwatersrand School of Psychology.

Professor Shmukler will be giving the first of two lectures on the role of psychiatry and psychology in society at the university's Centre for Continuing Education tomorrow evening.

She says there are many reasons why women predominate as pyschotherapy patients, an important one being the socialisation process.

"Women have always been encouraged to express or display their emotions more openly than men."

POSITIVE AND NEGATIVE

The women's movement has had positive and negative effects on women's emotional and psychological development, Professor Shmukler says.

On the one hand, there has been the positive element of stressing their rights which has led to enhanced self-esteem. On the other hand, the movement has put a lot more pressure on women.

"It was easier when roles were well-defined. With independence comes responsibility. Some people can't handle responsibility," Professor Shmukler says.

The women's movement has also brought problems for men as they struggle to cope with women's changing roles and status. A healthy result has been that more men are going into therapy, she says.

"Therapy is too good to be just for sick people," Professor Shmukler says, adding that it should not be accessible only to those who can afford it.

"Many people can benefit from enhanced growth, actualising potential and giving expression of the self in creative ways."

MISCONCEPTIONS

In her lectures she will look at misconceptions about psychology and psychiatry. Many people, she says, think of psychology only in terms of a clinical discipline.

"But there are many areas in training skills in which an understanding of psychology can be powerful and relevant, for instance, in education, the workplace today and community settings."

For psychology to be relevant in the present South African context, students need to be trained to have an understanding of where it can be applied beyond the middle-class, neurotic, affluent setting of individual psychotherapy, Professor Shmukler says.

Parents, teachers and others who are influential when personalities are being formed, should be educated to prevent mental problems.

● For more information on Professor Shmukler's lectures tomorrow and on March 15, telephone (011) 716-5509.

PC REPORT ON THE AGED

Health care: cutting reliance on the state

CAPE TOWN — No elderly person suffering from sickness, injury or the physical and mental effects of old age should forgo reasonable treatment because they were unable to pay, the Committee for Social Services has said in report on the aged.

However, everybody would have to become "more responsible" for financing their own medical and health care, the report, tabled in the President's Council yesterday, said.

"The State will become less and less able to provide heavily subsidised and expensive forms of medical services."

A further factor influencing individual medical self-sufficiency was that medical and health services would move in the direction of greater privatisation.

"This means that 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 committee recommended that the private sector be encouraged, by public education and tax incentives, to ensure that adaquate medical aid and insurance schemes were available.

In particular, the committee recommended that the National Health Policy Council (NHPC) question whether health maintenance organisations offered a new approach to the financing and provision of health care services.

Institutional care for the aged should be avoided as far as possible and state subsidies for the accommodation and care of the aged should be granted to individuals only when required. — Sapa.

Broader vision of care

CAPE TOWN — A "National Committee for the Care of the Aged", representative of all population groups, should be formed to function as part of the South African Welfare Council.

This was recommended by the Committee for Social Affairs in the report on the aged which was tabled in the President's Council yesterday.

The task of the proposed committee should be more comprehensive than merely social welfare, and should include all facets of the interests of aged people, with emphasis on social welfare, housing, health and economic matters.

The committee should establish a comprehensive policy for the care of the aged for SA which should be evaluated and adapted continuously to co-ordinate care for the aged at all levels.

Representatives from the private sector, drawn from the SA National Council for the Aged, welfare organisations, the business community, experts, and from the public sector, should sit on the committee.

The call for the formation of such a committee was made in view of findings that there was a lack of co-ordination and overlapping in many fields in this type of care.

Another finding of the Social Affairs Committee was that unrealistically high standards were set in providing facilities for the aged. — Sapa.

National pension proposed

CAPE TOWN — There should be wide-ranging changes in caring for and meeting the requirements of people over 65 years, and uses made of their expertise, knowledge and experience, recommends a President's Council report tabled yesterday.

Social Committee chairman Hein Kruger introduced the report, which includes the recommendation that a national contributory pension scheme for all South Africans be developed, on Tuesday.

The Committee found that lack of money was the dominant problem experienced by aged people and said the primary objective of a national pension scheme, which would initially be voluntary and later compulsory, would be to guarantee a minimum pension for everybody.

The report also recommended that incentives be more widely used to encourage donations to old age care projects. — Sapa.

The MINISTER OF COMMUNICATIONS:

	(a)	(b)
Lenasia	1 854	589
Soweto	18 669	1 413

Note: The information is in respect of main services only and includes transfers. The available statistics of telephones other than main services do not distinguish between services for private and business purposes.

Military disability pensions: persons in receipt/ amount paid out

365. Mr R M BURROWS asked the Minister of National Health and Population Development:

(a) How many persons are in receipt of military disability pensions and (b) what amount was paid out in such pensions in respect of the year ended 31 March 1987?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) 11 878

(b) R36 717 135

Commission of Inquiry into Health Matters: total amount spent

386. Dr M S BARNARD asked the Minister of National Health and Population Development:

(a) What total amount had been spent on the Commission of Inquiry into Health Matters as at the latest specified date for which figures are available and (b) on what specified items was this money spent?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) R507 431 as at 31/3/1987

(b) The funds were utilized as follows:

Salaries	R265 812
Administration	R68 455
Members' Allowances	R144 734
Publications	R27 747
Technical Services	R683
	R507 431

University of Natal: new teaching hospital for medical school

388. Dr M S BARNARD asked the Minister of National Health and Population Development:

With reference to his reply to Question No 187 on 27 July 1987, (a) what stage has been reached in the planning of the new teaching hospital for the medical school of the University of Natal and (b) when is it anticipated that construction will (i) commence and (ii) be completed?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) Accommodation schedules have been completed and consultants appointed.

(b) (i) On building site during 1990.

(ii) A 10-year project
(Depending on available funds.)

Hospital beds available/needed

389. Dr M S BARNARD asked the Minister of National Health and Population Development:

How many hospital beds were (a) available and (b) needed for (i) White and (ii) non-White patients in hospitals falling under the control of his Department as at the latest specified date for which figures are available?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) (i) 6 596

(ii) 15 985

(b) Beds needed are represented by building progamme: Major works 1991/92

(i) None

(ii) 4 802 beds
Specified date: 31/12/1987

State-financed hospitals: foreign patients treated

406. Dr M S BARNARD asked the Minister of National Health and Population Development:

(a) How many foreign patients were treated in State-financed hospitals in each province during the latest specified period of 12 months for which figures are available, (b) from which countries did these patients come, (c) what was the total cost to each province of these patients and (d) what amount of the fees payable was recovered from these patients in respect of each province?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

FOREIGN PATIENTS TREATED IN SOUTH AFRICAN PROVINCIAL HOSPITALS: PERIOD 1986-09-01 TO 1987-08-31

Country/City of origin	Province concerned	No. of patients	Hospital fees: Collectable R c	Collected R c	Written off R c
Argentinia	OFS	1	50,00	50,00	
Australia	Cape	3	201,00	40,00	
	OFS	1	40,00	40,00	
Austria	Cape	1	622,00		
Belgium	Cape	2	502,00	0,00	
	OFS	1	40,00	40,00	
	Transvaal	1	1 040,00	1 040,00	
Bophuthatswana	Transvaal	1	26,00	26,00	
Botswana	Cape	30	37 310,00	9,00	
	Natal	2	360,00	310,00	
	OFS	5	1 165,00	1 145,00	
	Transvaal	309	381 439,36	214 554,20	60,00
Bulgaria	Cape	1	1 494,00		
Canada	Cape	4	859,50		
Channel Islands	Natal	1	200,00		
China	OFS	41	2 682,00	2 462,00	40,00
Cyprus	OFS	3	170,00	130,00	
Denmark	Cape	1	137,00	137,00	
Egypt	Cape	1	530,00		
	OFS	1	50,00	50,00	
France	Cape	1	117,00	117,00	
	OFS	4	1 020,00	1 020,00	
Greece	Cape	3	879,00	829,00	
	Natal	1	100,00		
	OFS	3	850,00	850,00	
Ireland	Cape	2	204,00		
India	Cape	1	376,00		
	OFS	4	230,00	180,00	
Israel	Cape	8	7 485,00	7 054,00	
	OFS	1	10,00	10,00	
Italy	Cape	2	1 595,00	1 595,00	
	OFS	2	50,00	50,00	
Japan	Cape	15	12 076,00	1 313,00	
Kenya	Cape	3	132,25	132,25	
Korea	Cape	6	7 225,00	6 399,00	
Lesotho	Natal	4	596,00	292,00	
	OFS	1 258	662 786,00	467 038,00	1 260,00
	Transvaal	6	6 273,90	6 105,90	
Libanon	OFS	1	38,00	38,00	
Madagascar	Cape	4	1 296,00		
Malawi	Cape	12	9 932,00	4 859,00	
	Natal	3	400,00	50,00	
	OFS	2	270,00	270,00	
	Transvaal	27	27 114,41	14 058,51	
Mauritius	Cape	80	166 806,00	18 293,92	
	Natal	6	10 807,00	10 807,00	
	OFS	2	1 020,00		

Apartheid cause of crisis in health care — academic

Own Correspondent

Inadequate health care in South Africa could be cured only by establishing a single national health structure, a congress of 350 doctors has heard.

The health sector reflected inequalities found at all levels in the country and the worst primary health care was provided to those with the least political power, Mr Cedric de Beer of the department of community health at the University of the Witwatersrand said yesterday.

He was speaking at the 6th General Practioners' Congress in Cape Town.

Mr de Beer said the recent polio epidemics in Natal, the Baragwanath crisis and subsequent publicity about poor conditions at other black hospitals were indications that all was not well.

"Much of the shortfall in primary care can be explained by the racial politics of the country, as reflected in the segregation and fragmentation of the health services," he said.

What was needed was a single national structure responsible for the planning, co-ordination and implementation of health care, which was integrated racially and ethnically.

This would prevent the wasteful duplication of resources.

Mr de Beer said the present system was "highly fragmented", comprising:

- Ten homeland health departments.
- Three own affairs and one general affairs department.
- State, province and local authority services, racially divided.
- Separate public and private health sectors.

Substantial inequalities along black-white and urban-rural divisions could be found by comparing expenditure, distribution of doctors and availabiltiy of hospital beds.

In 1985, R451 per capita was spent on whites and R115 on blacks.

There was one doctor for every 2 320 people nationally, but up to one for every 33 000 people in the homelands.

There were 1,6 hopital beds per 1 000 in the homelands, 2,5 for blacks outside the homelands, and 4,8 per 1 000 for whites.

The "particular deprivation" of the homelands was because of their status as separate health care systems within independent states.

IN BRIEF

HOUSE OF ASSEMBLY — The black infant mortality rate in SA was more than 11 times as high as the white rate and more than double the coloured rate, Home Affairs Minister Stoffel Botha said yesterday.

The black infant mortality rate was estimated at 80 for 1 000 births.

He said 72 955 white children were born in 1986, 769 000 black children, 81 825 coloured children and 19 560 Asian children.

□□□

THERE were 1 128 strikes and work stoppages last year, 461 of which stemmed from wage demands, Manpower Minister Pietie du Plessis said in reply to Peter Soal (PFP, Johannesburg North).

The others were caused by grievances over working conditions, disciplinary measures and "various other reasons".

□□□

'Only single health dept can cure ills'

CAPE TOWN — Inadequate health care in SA could be cured only by the establishment of a single national health structure, a congress of 350 doctors was told yesterday.

The health sector reflected the inequalities found at all levels in the country and the poorest primary care was provided to those with the least political power, said C de Beer of the community health department at Wits University.

He was speaking at the sixth General Practitioners' Congress in Cape Town.

De Beer said the recent polio epidemics in Natal, the Baragwanath crisis and subsequent publicity about poor conditions at other black hospitals were indications that all was not well.

"Much of the shortfall in primary care can be explained by the racial politics of the country, as reflected in the segregation and fragmentation of the health services," he said.

What was needed was a single national structure responsible for the integrated planning, co-ordination and implementation of health care.

This would prevent wasteful duplication of resources. — Sapa.

D I D 18/3/88

Doctor: alternative health care needed

85

CAPE TOWN — South African medicine is locked into a decades-old policy of building bigger and better teaching hospitals.

The chairman of the South African Academy of Family Practice, Doctor Joseph H. Levenstein, said that there was an opportunity to make strides in caring for patients in the community, but a more equitable balance of resources was needed.

Dr Levenstein, head of the general practice unit at the University of Cape Town, said society could no longer afford to pay for limitless and sometimes inappropriate advances in medicine.

He said it was "ironic" that the new R200 million Groote Schuur teaching hospital was built when the Department of Health listed academic hospitals last on its list of health care priorities.

"In the 1950s and 1960s we capitalised on our unique situation of First World medicine in a Third World environment to blaze a trail of progress. The same opportunity exists again.

"This time we must focus our attention on the community with all that this implies," Dr Levenstein added. — Sapa

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(1) Whether he or any Deputy Ministers attached to the Ministry of Economic Affairs and Technology undertook any overseas visits in 1987; if so, (a) which countries were visited and (b) what was the purpose of each visit;

(2) whether he or these Deputy Ministers were accompanied by any representatives of the media on these visits; if so, (a) what were the names of the journalists involved, (b) which newspapers or radio or television networks did they represent, (c) to which countries did each of these persons accompany him or these Deputy Ministers and (d) why;

(3) whether any costs were incurred by the Department of (a) Trade and Industry and (b) Mineral and Energy Affairs as a result; if so, what total amount in that year in each case?

The MINISTER OF ECONOMIC AFFAIRS AND TECHNOLOGY:

(1) Yes, one visit abroad each by the Minister of Economic Affairs and Technology and the Deputy Minister of Economic Affairs and Technology (Dr T G Alant).

(a) Six countries by the Minister of Economic Affairs and Technology and one country by the Deputy Minister of Economic Affairs and Technology. In the circumstances of increasingly complex relationships that South Africa faces internationally it is not considered advisable to disclose the names of the individual countries.

(b) Minister of Economic Affairs and Technology

Strengthening of South Africa's trade ties through discussions with private businessman, organised trade and financial institutions, as well as with government representatives.

Visit to South African trade, mineral and energy missions as well as to offices of the South African Tourism Board to keep abreast of the latest developments there in a trade context and to have discussions with the representatives in the relevant missions.

Deputy Minister of Economic Affairs and Technology

Attendance of a specialised trade show and opening of the South African pavilion there. Addressing of and discussions with businessmen in order to create a better image of South Africa abroad.

(2) No

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

(3) (a) Yes.

Minister of Economic Affairs and Technology : R137 686
Deputy Minister of Economic Affairs and Technology : R23 024

(b) No.

Central Government agencies/institutions charged with health matters/care

645. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) What specified Central Government agencies and institutions are charged at present with the (a) collection, (b) collation, (c) analysis, (d) tubulation, (e) presentation and (f) publication of data relating to health matters such as (i) mortality and morbidity, (ii) facilities for and resources of health care and (iii) expenditure on health care;

(2) whether there are any procedures for use by Government agencies for the standardization and co-ordination of the determinants in collecting, collating, analysing, tubulating, presenting and publishing health-relevant data; if so, (a) what are these procedures, (b) by which Government agencies are they used and (c) which Government agencies (i) participated in the drafting of these procedures and (ii) monitor their implementation; if not, why not;

(3) whether procedures for the standardization and co-ordination of the determinants are to be drafted and implemented; if not, why not; if so, (a) by which Government agencies and (b) who will be responsible for monitoring their implementation;

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

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a)(b)(c)(d)(e)(f)(i)(ii)(iii)

Department of National Health and Population Development
Own Affairs Administrations
Provincial Administrations
Central Statistical Services
Local Authorities

(2) Yes;

(a) Expert committees, the Subcommittee on Health Statistics and Epidemiology.

(b) Department of National Health and Population Development
Own Affairs Administrations
Provincial Administrations
Local Authorities

(c) (i) As in 2(b)

(ii) Department of National Health and Population Development and the Subcommittee on Health Statistics and Epidemiology

(3) Yes.

(a) As in 2(b)

(b) As in 2(c)(ii)

(4) No.

Health matters: co-operation between Government agencies, private/parastatal agencies

649. Dr M S BARNARD asked the Minister of National Heath and Population Development:

Whether Government agencies co-operate with any private or para-statal agencies and institutions in collecting, collating, analysing, tabulating, presenting and publishing data relating to health matters; if not, why not; if so, with which agencies or institutions?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Yes:—

The South African Medical Research Council, Council for Scientific and Industrial Research, Human Sciences Research Council, Development Bank of Southern Africa, Professional Boards and the Regional Health Organisation for Southern Africa.

Health needs: Government agencies consulting with experts

650. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether Government agencies charged with the collection, collation, analysis, tabulation, presentation and publication of data on health matters, have developed procedures for consulting with experts in specific areas to ensure that material relevant to health needs is included in their data; if so, (a) what procedures have been developed and (b) which agencies and/or experts are consulted in this regard; if not, why not;

(2) whether procedures for consultation are to be developed; if not, why not; if so, which agencies and/or experts will be consulted?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes.

(a) Expert Committees.

(b) Service rendering bodies as well as the Medical Research Council, the Council for Scientific and Industrial Research and the Human Science Research Council.

(2) Falls away.

Health matters: making available of information

651. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether there are procedures for making available to accredited individuals, agencies and institutions information on health matters collected or processed by Government agencies; if not, what action is to be taken in this regard; if so, (a) what are these procedures and (b)(i) at what intervals and (ii) in which publications is this information published;

(2) whether a fully compatible computer network for information-sharing is used for the transmission of information between Government agencies and private and

parastatal agencies and institutions; if not, why not; if so, what is the (a) nature and (b) extent of that network;

(3) whether computer technology is utilized in making information available to other individuals, agencies and institutions; if so, (a) what is the nature of the technology utilized and (b) in respect of which other individuals, agencies and/or institutions is it utilized?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes;

(a) Reports and publications

(b) (i) Monthly and annually

(ii) Annual Reports
Population Development Program:
Monitoring Reports
Epidemiological Comments
Departmental Publications
General Media

(2) and (3) This matter is currently being considered by the Commission for Administration.

Health data-handling: amount spent

652. Dr M S BARNARD asked the Minister of National Health and Population Development:

(a) What was the total amount spent on health-data handling by each specified Government agency in the 1987-88 financial year and (b) what amount was spent by his Department in respect of honouring financial commitments to para-statal and other contractual data-handling bodies in that year?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) R1 126 371,00 in respect of the Department of National Health and Population Development.

Figures in respect of other Government agencies are not readily available.

(b) R815 000,00.

Notifiable medical conditions

653. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) (a) What specified medical conditions are currently notifiable and (b) when was this list drafted;

(2) whether a new list of notifiable medical conditions is being or has been drafted; if so, (a) what additional medical conditions are being or were considered for this new list, (b) which Central Government agencies are or were responsible for drafting this new list and (c) which other Government, parastatal or private agencies or individuals will be or were consulted in the drafting of this new list; if not, why not;

(3) whether, in view of the changing pattern of diseases as well as alternative methods of disease surveillance, consideration is being given to drafting a new list; if not, why not; if so, when is this new list due to be completed;

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

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) List of Notifiable Diseases

Anthrax
Bruccellosis
Cholera
Diphtheria
Haemorrhagic Fevers of Africa (Congo Fever, Dengue Fever, Ebola Fever, Lassa Fever, Marburg Fever, Rift Valley Fever).
Lead poisoning
Leprosy
Leptospirosis
Malaria
Measles
Meningococcal Meningitis (including Meningococcaemia).
Paratyphoid Fever
Plague
Poisoning from any agricultural or stock remedy registered in terms of the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies Act, 1947 (Act 36 of 1947), as amended.
Poliomyelitis
Primary malignancy of the bronchus, lung and pleura
Rabies
Smallpox (all forms)

Tetanus
Toxoplasmosis
Trachoma
Trypanosomiasis
Tuberculosis (all forms of tuberculosis are notifiable, except cases diagnosed solely on the basis of clinical signs and symptoms and/or a positive tuberculin test).
Typhoid Fever
Typhus Fever (epidemic lice typhus fever, endemic ratflea typhus fever)
Viral Hepatitis A and B and undifferentiated Yellow Fever

(b) In the months preceding the publication of Regulation R1802 of 24 August 1979.

(2) No.

(a), (b), (c) fall away. Because the revised list can only be drafted once all the interested parties have been informed and consulted. This process is in the planning phase.

(3) Yes.

Probably during the second half of 1988.

(4) No.

Notifiable medical conditions: level at which information is collected

654. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether information in respect of notifiable medical conditions is collected at the (a) point of diagnosis and (b)(i) local authority, (ii) regional health directorate and (iii) directorate of epidemiology level; if not, at what point or level is this information collected;

(2) who is responsible for collating, analysing, tabulating and publishing information in respect of notifiable medical conditions;

(3) what (a) is the average time-delay between the (i) diagnosis of notifiable medical conditions and (ii) publication of the tabulated findings by the directorate of epidemiology in his Department and (b) are the reasons for the delay;

(4) what action is taken against local authorities which fail to comply timeously with the provisions of section 28 of the Health Act, No 63 of 1977?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) Yes.

(b) (i) Yes.

(ii) Yes.

(iii) Yes.

(2) There is no legal responsibility in this regard. The analysis of data in respect of notifiable diseases and the publication of the results are undertaken as a service at the discretion of the Director-General.

(3) (a)(i) and (ii) There is no such thing as an "average time-delay" in this context.

(b) The delay between diagnosis and publication of tabulated findings changes with time, with the disease in question, with the notifying authority and is also dependent on technical and administrative factors.

(4) None.

Pensionable service: new conditions on buying back

655. Mr R M BURROWS asked the Minister of National Health and Population Development

(1) On what date in the latter half of 1987 did his Department impose new conditions on the buying back of pensionable service;

(2) whether Government Departments handling applications for the buying back of service act as agents for his Department in the processing of such applications;

(3) whether applications that were in the possession of Government Departments but had not yet been received by the head-office of his Department in Pretoria as at the above date, have been considered for buy-back purposes; if not, why not; if so, on whose decision;

(4) whether, in making known the new conditions for the buying back of pensionable service, he or his Department consulted with any representatives of staff associations; if so, (a) with which associations and (b) on what dates?

DD 8/4/86 (85)

Masa concerned by article

Daily Dispatch Correspondent

CAPE TOWN — The Medical Association of South Africa (Masa) has expressed serious concern over a recent article on South African child detentions in the influential British medical journal, The Lancet, which contained criticisms of Masa and the South African medical profession.

The secretary general of Masa, Dr Marais Viljoen, said yesterday the article was "shocking and vastly disturbing".

Masa would be taking the matter up with The Lancet and the World Medical Association, and would voice its reaction in the South African Medical Journal.

In highlighting "the widespread detention and torture of children in South Africa", The Lancet article accused the official South African medical bodies of never having made an adequate response.

It criticised the guidelines on conditions and treatment of children in detention produced by Masa and the South African Paediatric Association last year, saying they ignored the central question of the detention of children.

It quoted a statement by a former Port Elizabeth district surgeon, Dr Wendy Orr, to the Harare conference on detentions in South Africa, where she asked why Masa and the South African Medical and Dental Council had not acted to bring doctors to task who did not report torture.

Responding to the article, Dr Viljoen said none of the "many terrible allegations" was substantiated anywhere.

SA medics upset at UK criticism

(85 B/day) ROGER SMITH (358) 8/4/88

THE Medical Association of SA (Masa) has expressed concern over a recent article on SA child detentions in the influential British medical journal, The Lancet, which contained criticisms of Masa and the SA medical profession.

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Political comment in this issue by Ken Owen. Newsbills by Gerald Prosalendis. Headlines and sub-editing by Michael Moon. All of Times Media Ltd, 11 Diagonal Street, Johannesburg.

D1D 81488 (85)

Namda holds congress

EAST LONDON —The annual conference of the Eastern Cape branch of the National Medical and Dental Association (Namda) will start at Dower College in Port Elizabeth today.

The theme of the conference is "People's health —the way forward" and it will be addressed by the director of the Hesperian Foundation in California, Mr David Werner, and a health planner attached to the World Health Organisation in Finland, Mr Harkan Hellberg.

Mr Hellberg will deliver the keynote address, while Mr Werner, who is well known for his critiques on primary health care systems, will assess the South African situation.

The dental symposium will be chaired by Professor Gordon Mattison, of Florida, in the United States, and will concentrate on endodontics.

Many national speakers will cover a broad range of health-related topics and the conference will close at the end of the weekend. — DDR

DD 11/4/88

SA denies US delegation visas

85

Daily Dispatch Correspondent

JOHANNESBURG — The government has refused to grant visas to a seven-member medical delegation from the American Association for the Advancement of Science (AAAS).

The team's visit was due to have started on Firday and ended on April 15.

A spokesman for the Department of Home Affairs confirmed that the visas had been refused but would not disclose reasons for the decision.

According to a statement from Wits University Medical School, the members were on the AAAS committee on scientific freedom and responsibility.

They were to have met South African doctors and others "to discuss how the state of emergency has affected the provision of medical services to the general population, including detainees".

The dean of the faculty of medicine, Professor Clive Rosendorff, criticised the government's move and said the AAAS, the largest scientific organisation in the US, "might well conclude the South African Goverment has much to hide".

He said the authorities presumably felt the visit would constitute interference in South Africa's internal affairs.

"Concerned doctors and other health professionals would, however, have welcomed the opportunity of discussing the effects of apartheid on the provision of health services and other medical issues of mutual concern."

"We would all have benefitted from this type of contact at a time when the South African medical profession is finding itself increasingly isolated from world medicine and science."

The delegation was to have been led by a specialist on human rights and the health professions, Dr Elena Nightingale.

Included in the group were prominent US doctors and psychiatrists, the director of the American Psychiatric Association, and the director of the AAAS Science and Human Rights Programme.

Dullah Omar (right) and Govan Mbeki in conversation

Namda applauds Mbeki

PORT ELIZABETH - Former Robben Island prisoner Govan Mbeki was invited to to deliver the keynote address at the National Medical and Dental Association's fifth annual conference this week, but because of restrictions was unable to do so.

Mbeki however walked onto the stage with fist clenched to applause from 300 delelgates.

His presence at the conference symbolised the leadership of Oliver Tambo, Nelson Mandela and others in jail, Namda president Diliza Mji said.

The political situation in the country continued to be the single most important cause of ill health and disease. The solution to the health crisis in South Africa lay in the fundamental restructuring of the socio-political situation.

Dullah Omar, vice-president of the National Association of Democratic Lawyers, said in the keynote address that Namda had brought medical professionals directly into the liberation struggle.

Namda has highlighted the connection between apartheid and the poor health.

A paper by Rev Mcebisi Xundu, chairperson of the East Cape Council of Churches, urged medical professionals to guard against becoming alienated from disadvantaged communities by the class interests that their professionalism brought.

'Health power'

From EDYTH BULBRING

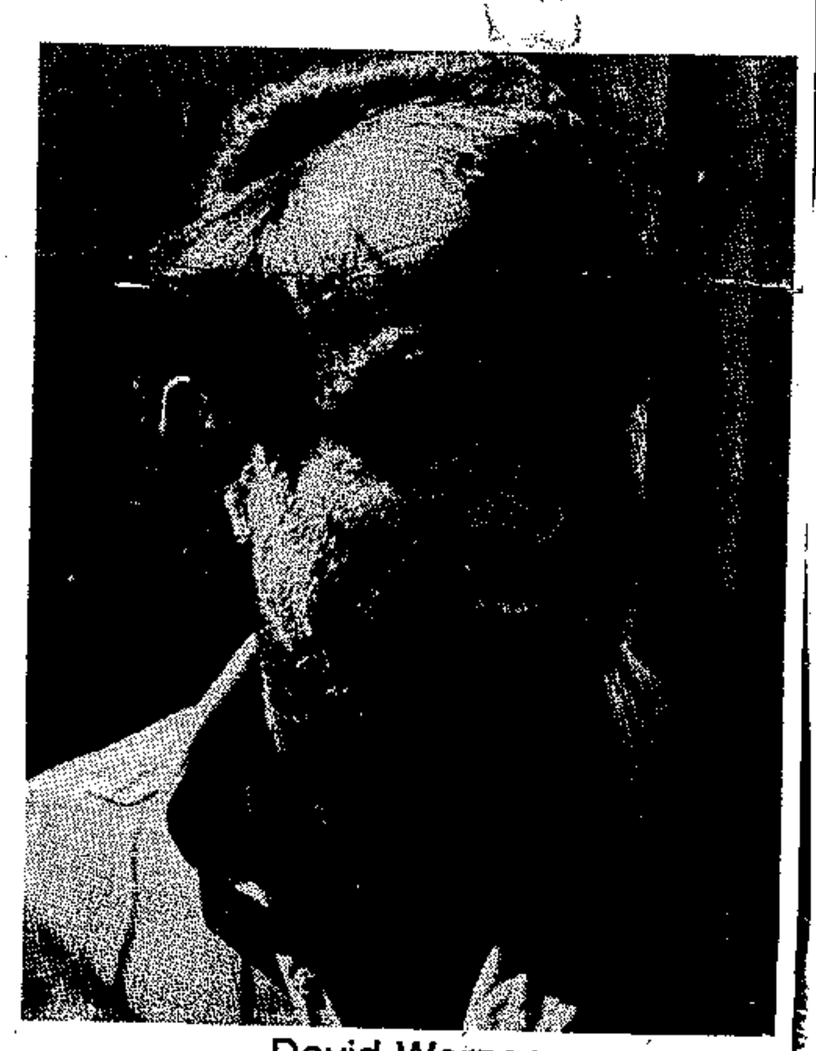
PORT ELIZABETH. - David Werner, guest speaker at the National Medical and Dental Association's fifth national conference, had no formal medical training.

But in the past ten years American born Werner has been a consultant in primary health care to the World Health Organisation, the Pan American Health Organisation and to UNICEF.

He has travelled widely in South America, Africa and India speaking on primary health care and training health care workers all over the world.

Werner, 53, became involved in the medical world by chance. He said while on vacation in Western Mexico he saw the health problems of peasant farmers.

"I was more interested in birds and plants at the time, but after spending some weeks with the villagers in their homes and seeing the severity of their problems, I saw that with improved resources and information people could manage better."



David Werner

Liberation theology

Werner who has science degree in ecology and zoology, and graduate studies in English poetry and theatre, took a year leave of absence from the pricate Californian school where he was a science teacher and returned to the mountains of Western Mexico. He ended up staying ten years.

Here he founded "Project Piaxtla", a primary health situation of the families was in crisis.

"Thirty four percent of children died in the first five years of life, primarily from diarrhoea and infectious diseases. Seventy percent of women were visibly anaemic and about ten percent died during or after childbirth," Werner said.

As the guest speaker at the NAMDA conference, Werner uses the example of Project Piaxtla to illustate how a community health programme evolved into an "empowering" process whereby poor families took control over circumstances that kept them in poor health.

The concept of "empowerment" in the health arena has a crude parallel in liberation theology. "It is liberation theology without the theology. It is a liberating grassroots concept with a socio-political goal — the equalising of power and basic rights."

Werner's bottom line is that health depends more on empowerment of the people than it does on health care.

But he takes this one step further. In attaining health, that is social, physical and mental well-being, a community will liberate itself.

Werner contends that poor health results from "unfair distribution of land, resources, knowledge and power - too much in the hands of too few".

By "empowerment", disadvantaged people work together to increase control over events that determine their lives, and is a process achieved by the people themselves.

Primary health care is a comprehensive process whereby people work together to improve the total situation of communities and to deal with the underlying causes of poor health.

Because of its revolutionary potential, it had

"Repressive governments have good reason to fear the empowering potential of community-directed health care initiatives because non-government community health programmes and workers more often become the focal points of community organisation which has helped to strengthen popular movements for social transformation."

Werner laments the UNICEF "adjustment policy" for health care decided on at the last global policy planning meeting. Acknowledging the dependency of the third world on first world countries, UNICEF has proposed a variety of alternative measures for health care.

It is based on "selective primary health care" focusing on the disease rather than the cause of illness. Although Werner feels that this selective approach can alleviate death or disease on a short term basis, it sacrifies the liberatory effect that a comprehensive primary health care programme brings.

Another problem with this selective approach, Werner stresses is that health priorities are not decided by the disadvantaged communities but by the central authorities, businessmen and even foreign"experts".

"Rather than promote greater equity, too often it further entrenches and legitimises the existing inequitable power structure" he said.

Werner emphasised that health care should be

without doctors

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EDYTH BÜLBRING reports from the NAMDA conference

Werner and back braces at prices the community can afford.

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As members of the community who had previously been scorned, they had now become respected. Werner said farmers even came to the disabled health workers for help in their farming equipment.

enuity, nstruct elchairs

The death rate of children has dropped from 34 to seven percent. But with the successes that the project has brought, so attempts have been made to close the project down. Werner said health workers and members of the farm workers organisation had been repeatedly jailed and threatened.

The government has introduced health programmes, one after the other, into the area, neglecting areas with no health programmes in an attempt to undermine the project.

Werner emphasises that doctors should become teachers, passing on skills to the community and allowing people to treat each other.

He feels doctors should work at demystifying medicine and training people in the community in primary health care. In this way, the power of health is placed in the hands of the people most affected.

The concept of "empowerment" in the health arena has a vague parallel in liberation theology. "It is liberation theology without the theology. It is a liberating grassroots concept with a socio-political goal, the equalising of power and basic rights," he said.

Health, he says, depends more on empowerment of and by the people than it does on health care *per se*.

But he takes this one step further: in attaining health, defined as social, physical and mental well-being, a community will liberate itself.

Werner contends poor health results from "unfair distribution of land, resources, knowledge and power — too much in the hands of too few".

By empowerment, disadvantaged people work together to increase their control over events that determine their lives.

Because of its revolutionary potential, it has been opposed in many countries, Werner says.

"Repressive governments have good reason to fear the empowering potential of community-directed health care initiatives because non-government community health programmes and workers more often become the focal points of community organisation, which has helped to strengthen popular movements for social transformation," he says.

PEN

Govan Mbeki with lawyer Dullah Omar, who replaced him as keynote speaker

Health with

The man who stole the show at a medical confe not a doctor. He is an ex-science teacher whc mountains of Mexico, and there engineered a re

EDYTH BÜLBRING reports

DAVID WERNER, guest speaker at the weekend at the conference of the National Medical and Dental Association, has had no formal medical training.

But in the last 10 years, American-born Werner has been a consultant in primary health care to the World Health Organisation, the Pan American Health Organisation and to the United Nations Children's Fund.

He has travelled widely in South America, Africa and India speaking on primary health care and training health care workers all over the world.

Werner, 53, became involved in the medical arena by chance. While on vacation in western Mexico he noticed the health problems of peasant farmers.

"I was more interested in birds and plants at the time, but after spending some weeks with the villagers in their homes and seeing the severity of their problems, I saw that with improved resources and information, people could manage better," he says.

Werner, who had a BSc degree in ecology and zoology and had begun graduate studies in English poetry and theatre, took a year's leave of absence from the private Californian school where he was a science teacher and returned to the mountains of western Mexico. He ended up staying 10 years.

Here he founded "Project Piaxtla", a primary health care network run and staffed by villagers. In 1965, when the project began, the health situation of the families was in crisis.

"Thirty-four percent of children died in the first five years of life, primarily from diarhhoea and infectious diseases. Seventy percent of women were visibly anaemic and about 10 percent died during or after childbirth," Werner says.

He uses the example of Project Piaxtla to illustate how a community health programme evolved into an "empowering" process, whereby poor families took control over the circumstances that had kept them in poor health.

In 1965 when the "Project Piaxtla" health programme began, the economic base of the farmers was the primary cause of poverty and ill health.

The rich "river bottom" land, officially due for redistribution, was illegally held by a few rich farmers. Poor families had no choice but to sharecrop or to subsist on poorer land on the hillsides.

Local political power was controlled by the bottom-land owners and when poor farmers attempted to take over the land, they were killed or jailed.

At the outset, Project Piaxtla focused on curative self-care, but shifted to preventative measures — vaccinations and the building of latrines and water delivery systems.

As the project developed the people saw their main obstacle to health as poverty and began to organise to improve their economic base.

They established co-operative maize banks which stopped the practice of borrowing maize from the bottom land owners at high interest. Through the organisation of poor farmers, workers took over the community council which had been controlled by the big landowners.

They then fenced off their land, whose crops were being destroyed by cattle belonging to the landowners, and started renting grazing rights.

The farmworkers then began to take possession of the river bottom land. When the land reform authorities at state level refused to back them, they sent a committee to the ministry of land reform in Mexico City and won their demands.

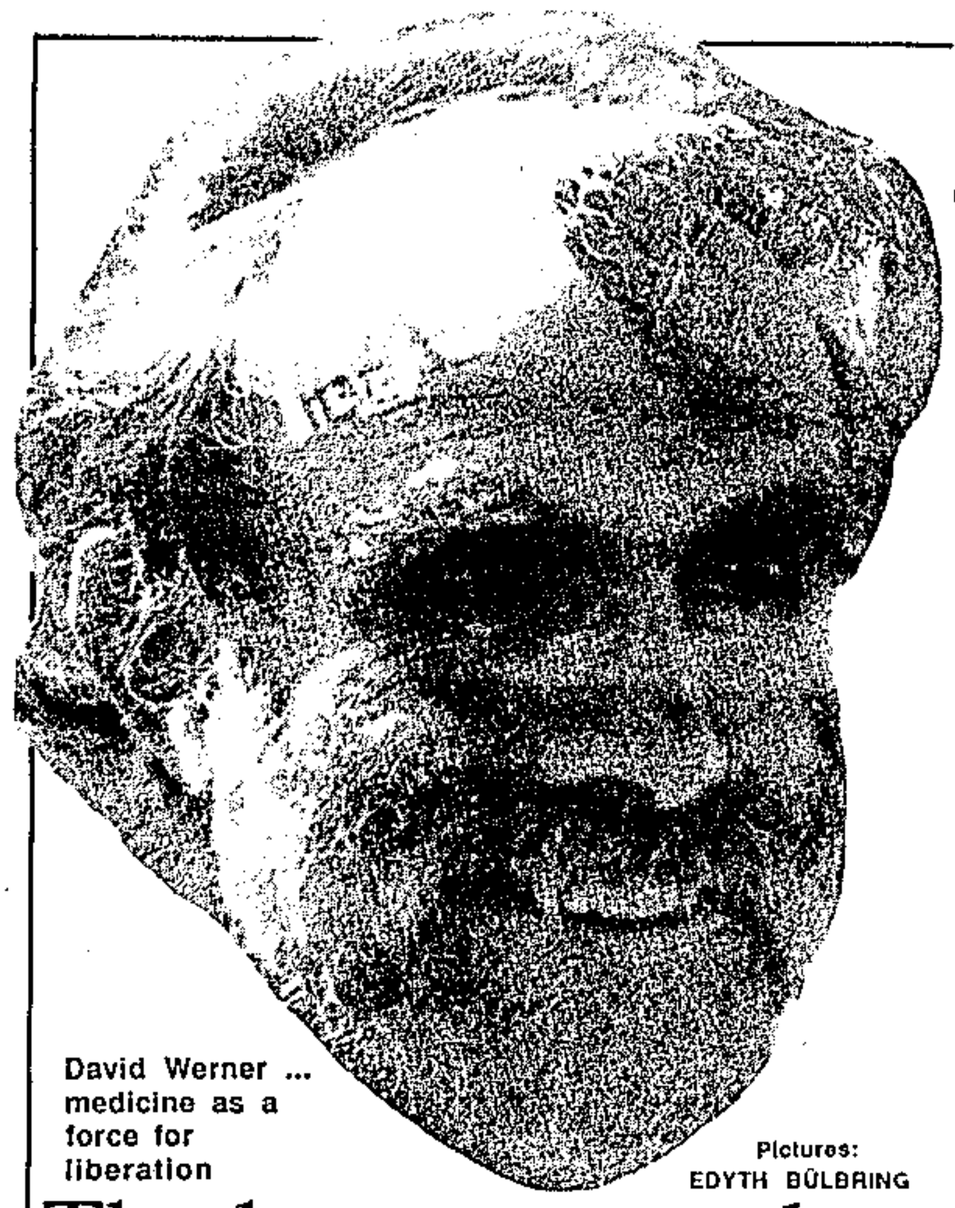
They have now began to irrigate their lands, more food is grown and child and maternal mortality continue to decline.

Project Piaxtla has also given rise to a sister programme, Proiima, run for and by disabled persons. Werner showed how a team of disabled rehabilitation workers, the majority with no formal medical training, manage to help people become independent and self reliant.

By using initiative and ingenuity, disabled health workers construct medical equipment like wheelchairs and back braces at prices the community can afford.

As members of the community who had previously been scorned, they had now become respected. Werner said farmers even came to the disabled health workers for help in their farming equipment.

The death rate of children has



David Werner ... medicine as a force for liberation

Pictures: EDYTH BÜLBRING

The keynote speaker who said not a word

THE mood was set at the National Medical and Dental Association's fifth national conference at the weekend by the presence of former Robben Island prisoner, Govan Mbeki.

As he walked up to the platform, accompanied by a standing ovation from the audience, he raised his fist.

Mbeki had been invited to deliver the keynote address — which, Namda president Diliza Mji informed over 300 delegates, he had been unable to do because of government restrictions.

But his presence at the conference symbolised the presence of the "entire national leadership, including your comrades-in-arms, Nelson Mandela, Oliver Tambo and all others in jail", Mji said.

He said the political situation in the country continued to be the single most important cause of ill health and disease. The solution to the health crisis lay in the fundamental restructuring of the socio-political situation.

The health crisis amongst the majority of South Africans, he said, was linked to the political crisis, where resources were distributed unevenly. "(President PW) Botha's economic policy is detrimental to health," he said.

From its formation in 1982, Namda has highlighted the connection between apartheid and the poor health of the majority of South Africans.

The title of this year's conference — "People's health, the way forward" — focused discussion at the conference on the role of medical professionals as teachers, identifying with the community's interests and putting the tools of health care into the hands of people in the communities.

A paper by Rev Mcebisi Xundu, chairman of the East Cape Council of Churches, urged medical professionals to guard against becoming alienated from disadvantaged communities by the class interests their professionalism brought.

It was strongly argued at the conference that doctors should demystify their skills and in equipping health care workers in the community with medical skills, empower communities to control their health.

Melanie Alperstein, a co-ordinator of a village health project under the auspices of the Health Care Trust, outlined a seven-year project aimed at training health workers in villages near Cala, Transkei.

In addition to training village health workers, elected by the community to deal with common illnesses, the project has also improved the economic base of the community by extending to gardening and water projects.

The project wanted to make it possible for people to acquire the skills and techniques necessary to deal with their problems and to exercise skills collectively.

The work of the village health workers was to be mainly preventative, as specified by the Transkei Department of Health.

The project experienced enormous problems: tension between the medical staff from the hospital and clinic in Cala and the village health workers; obstruction by sub-headmen.

The latter group had to be be won over by inclusion in committees; once involved, they became more cooperative. However, the rule of headmen and tribal authorities remains autocratic and unchallenged as no extra-government organisations are allowed to exist in the Transkei, Alperstein said.

As for the hostile attitude of hospital and clinic staff, that was "largely due to the common attitude of professionals not recognising the capabilities of non-professionals", Alperstein said.

Alperstein was deported from the Transkei in October 1986. — PEN.

Mji on doctors as teacher

NAMDA president Diliza Mji called for a comprehensive approach to health by health workers; otherwise their impact would be negligible. He said medical professionals should work towards a process of "empowerment" with the community as advocated by speaker David Werner.

He said the relationship between doctor and patient had to be reviewed, where doctors become teachers and work with a community, involving them in decisions and elliminating the dependency relationship.

Mji said Namda would be working towards organising nurses — the biggest sector in the medical profession — and would intensify its campaign for a national health service. — PEN.

Health services' aim

HOUSE OF ASSEMBLY — The important question in SA's health services was not whether people of different races were lying next to each other in the same hospital ward, but the quality of the care they were receiving, Minister of Health Dr Willie van Niekerk said yesterday.

He said in reply to committee stage debate on his vote that his administration strove to give the best quality health care to every patient, regardless of race creed or colour.

"Even if he is lying on the floor," interjected Rupert Lorimer (PFP Orange Grove).

Van Niekerk said he wanted to assure Members that the needs of Baragwanath Hospital were a top priority with the Minister of Finance.

"I believe we must do something not only about Baragwanath as such but also about opening up other hospital beds and clinics in the area," he said.

Van Niekerk said the investigation by Dr Wim de Villiers into the high cost of medicines — an issue which he himself was very concerned about — was far advanced and would soon be completed.

Discussing the floods, he said the public donated R23,4m to the relief fund. He added there were still flood victims without possessions who had to be fed. — Sapa.

B/day 25/4/88.

Concern over the rising cost of health

GERALD REILLY

THE escalating costs of health services was a "tremendous concern" to the National Health Department, health director general C F Slabber said at the weekend.

Speaking at a Pharmaceutical Manufacturers Association banquet in Johannesburg on Friday night, he said the high costs of medicines was causing the greatest concern. Apart from salaries, medicine was the largest single item of expenditure on providing services.

The tender prices of certain medicines had increased by 40% in the past year. The average increase was 30%.

It was disturbing that the largest single item of expenditure by medical aid funds in the past five years was medicine. In 1986 the figure was R538,6m — an increase of 29,8% on the '85 figure. The figure for 1987 would probably exceed 30%.

Slabber asked whether manufacturers were doing all they could to reduce the cost of medicine. He found it puzzling that it was often possible for a wholesaler to buy medicine cheaper from a medical practitioner than directly from the manufacturer. A problem was that the discount given by the wholesaler was seldom passed onto the consumer. Why could not the wholsaler lower his profit margin and do away with the discount, he asked.

Promotional costs of pharmaceutical companies had been identified by the Brown commission at an average of 23%. He found it difficult to reconcile the figure.

These practices continue to cause problems in the marketplace and the time was probably opportune to re-examine their value.

It was disturbing to read that a certain company, by raising its turnover by only 17%, increased its after-tax profit by 510% with the main share coming from its pharmaceutical activity, Slabber said.

DID 26/4/88

Professor defends acne pill

JOHANNESBURG — The chairman of the Medicine Control Board, Professor Peter Solb, said there were no reports in South Africa of birth defects caused by the use of the anti-acne drug, Roaccutane.

Prof Solb said a survey by a team from the University of Cape Town had not found any defects caused by Roaccutane since its introduction in 1983.

Reacting to recent reports of several birth defects caused by the drug in the United States, he said there was no reason to take the drug off the market.

However, he warned doctors to ensure that patients were not pregnant before prescribing the drug. — Sapa

The MINISTER OF LAW AND ORDER:

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

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

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

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

The MINISTER OF DEFENCE:

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

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

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

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

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

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

Transfer of local government functions

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

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

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

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

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

(1) No.

(a) The investigation is extensive and complicated.

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

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

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

(3) Falls away.

Privatization of hospitals/health facilities

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

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

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

HOUSE OF ASSEMBLY

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

To questions No. 897, 898 and 899.

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

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

(2) No.

Privatization of hospitals/health facilities

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

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

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

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

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

Privatization of hospitals/health facilities

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

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

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

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

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

Employees: extra employment/own businesses

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

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

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

The STATE PRESIDENT:

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

Employees: extra employment/own businesses

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

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

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

The MINISTER FOR ADMINISTRATION AND PRIVATISATION:

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

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

HOUSE OF ASSEMBLY

occupational rehabilitation centres since September 1984; if so, (a) where and (b) when; if not, (i) why not and (ii) what steps have been or are to be taken to establish such centres.

The MINISTER OF HEALTH SERVICES AND WELFARE:

No

(a) and (b) Not applicable

(i) No funds were available.

(ii) The first centre will be commenced with during 1988/89.

Approved posts: vacancies

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

(1) How many approved posts for (a) dentists, (b) physiotherapists, (c) speech therapists and (d) environmental hygienists are there in his Department;

(2) whether any of these posts are vacant; if so, (a) how many in each category and (b) in respect of what date is this information furnished;

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

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) (a) 21

(b) 1

(c) 3

(d) None

(2) Yes

(a) 4 dentists posts.

(b) 30 April 1988.

(3) No.

QUESTIONS UNDER NAME OF MEMBER

(3) (a) As prescribed by the National Building Regulations.

(b) R12,50 per month.

(4) (a) Site C — 167 ha.

Village 3 and 4 of Town 1-240 ha.

(b) Government land — R242 016.

Applications to train as nurses

900. Dr M S BARNARD asked the Minister of Constitutional Development and Planning:

Whether any applications to train as nurses at institutions for the training of (a) White, (b) Coloured, (c) Indian and (d) Black nurses were not accepted in the current year; if so, (i)(aa) how many, and (bb) why, in each case, and (ii) in respect of what date is this information furnished?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This information was furnished by the different Provincial Governments:

(a), (b), (c) and (d) Yes.

(i)(aa).

TRANSVAAL

White	— 597
Coloured	— 216
Indian	— 132
Black	— 877

CAPE PROVINCE

White	— 486
Coloured	— 3 589
Indian	— 232
Black	— 6 890

(Charlotte Searle College does not keep statistics in this regard).

ORANGE FREE STATE

White	— 61
Coloureds, Indians and Blacks	— 6 415

(These are regarded, for training purposes, as one group).

NATAL

Figures cannot be furnished as no records are kept of applicants who were not accepted.

(i) (bb) Due to the following reasons:

— The educational qualifications of candidates were not suitable.

— Not enough vacant posts available.

— Weak symbols.

— Erroneous completion of application form.

— Applicants did not turn up for the selection.

— Medically unfit.

— Not resident in the area served by the college concerned.

(ii) 1988-applications.

Nurses: resignations during course of training

901. Dr M S BARNARD asked the Minister of Constitutional Development and Planning:

Whether any (a) White, (b) Coloured, (c) Indian and (d) Black nurses accepted for training courses at institutions for the training of nurses resigned in the course of their training during the latest specified 12-month period for which information is available; if so, how many in each case in each specified year of study?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This information was furnished by the different Provincial Governments:

CAPE PROVINCE

Yes, for the period 1 January 1987 to 31 December 1987.

Race	Resignations according to year of study			
	1st year	2nd year	3rd year	4th year
(a) White	92	37	8	0
(b) Coloured	70	23	8	0
(c) Indian	—	—	—	—
(d) Black	7	4	6	0

ORANGE FREE STATE

Yes, for the period 1 January 1987 to 31 December 1987.

Race	Resignations according to year of study			
	1st year	2nd year	3rd year	4th year
(a) White	52	27	6	3
(b) Coloured	—	—	—	—
(c) Indian	—	—	—	—
(d) Black	5	6	—	1

TRANSVAAL

Yes, for the period 1 January 1987 to 31 December 1987.

Race	Resignations according to year of study			
	1st year	2nd year	3rd year	4th year
(a) White	211	82	74	12
(b) Coloured	9	13	1	—
(c) Indian	3	—	1	—
(d) Black	41	47	23	—

NATAL

Yes, for the period 1 January 1987 to 31 March 1988.

Race	Resignations according to year of study			
	1st year	2nd year	3rd year	4th year
(a) White	34	31	2	—
(b) Coloured	—	1	—	—
(c) Indian	4	22	—	—
(d) Black	9	11	—	—

Hospital beds

978. Dr M S BARNARD asked the Minister of Constitutional Development and Planning:

(1) How many hospital beds are there at the (a) Groote Schuur, (b) Red Cross War Memorial, (c) Tygerberg, (d) Woodstock and (e) New Somerset Hospital;

(2) whether any of these hospitals are racially integrated; if so, which hospitals;

(3) whether any of these hospitals are racially segregated; if so, how many beds are reserved for (a) Whites, (b) Coloureds, (c) Blacks and (d) Asians in each such hospital;

(4) what is the average bed occupancy in each of these hospitals in respect of each race group?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

This information was furnished by the Cape Provincial Government:

(1) (a) 1 467

(b) 347

(c) 2 106

(d) 175

(e) 437

2, 3 and 4.

There is no stipulated restriction placed on the utilisation of provincial hospital facilities purely for one specific population group only at the relevant hospitals. For example, the official allocated beds for White and non-White at the three academic hospitals are utilised in such a way that maximum benefit is achieved and an acceptable health service is rendered to all population groups within the framework of policy laid down. There are, however, wards in the five hospitals for the predominant use of a specific population group in accordance with stated policy, whilst at the Groote Schuur, Red Cross War Memorial, Tygerberg and New Somerset Hospitals central bed facilities are available which can be utilised for all population groups according to medical criteria. Separate statistics are, however, not kept for Coloureds, Asians and Blacks. A distinction is made only between White and non-White.

In order to illustrate these comments, the following statistics are provided:

'Public will pay dearly for health privatisation'

By Jo-Anne Collinge Star 10/5/05

A sombre warning that the public will pay dearly if it meekly accepts the privatisation of health care services has been sounded by Professor Dingie van Rensburg, head of the department of sociology at the University of the Free State.

"Health and care are not commodities. They are not simply an individual responsibility and a privilege reserved only for certain people. It borders on the immoral to make a profit out of health care," Professor van Rensburg says in an article in his university's journal, *Acta*.

"Privatisation of health care is in the interests of many other groups, but it is in many respects not in the interests of the most important group — the patients.

"The broader community, which consists of patients, will pay heavily for uncritically accepting the privatisation of health care services — the poor with privation and those that can comfortably afford it for the profits and wastage that necessarily can take place."

Professor van Rensburg says that a simplistic economic model of free enterprise has been generalised to health care, whether it suits that purpose or not.

A power elite of politicians and businessmen has set the nation on course for privatisation wherever possible — and the layman has uncritically bought the idea that it must be in everyone's best interests if health services were to become a private initiative.

In doing so, the public accepts a whole package of principles and practices — "the good, the less good and the bad".

"With the privatisation of health care, South Africans have accepted the more serious side-effects of the free enterprise system and of capitalism. These include possible problems concerning inequality in health provision; financial exclusion; a second class health system; first and second class health services and first and second class patients; profit-seeking, monopoly interests and even exploitation."

W Mail 13-19/5/88

New tariffs make health a 'privileged commmodity' (85)

By CARMEL RICKARD, Durban

NEW hospital tariffs make health "an exclusive commodity" affordable only by some.

That's the view of the Natal-based Health Workers' Organisation whose members have drawn up a dossier on the new system, criticising the fact that neither doctors nor any other group of health workers was consulted about the issue.

They complain that the new tariffs disregard the "essential needs of the poorer community".

In terms of the new system, introduced last month, tariffs are worked out after a detailed financial assessment of each patient.

One aspect of the policy which particularly concerns the HWO is revealed in an official document on the new procedures which states that "curative health services, in general, should (except for emergencies), be regarded as a privilege and not a right. The public should therefore make provision for such a service either by insurance or direct payment".

In terms of the directive, the exception (emergency treatment) should be given to "any patient without question or delay at any provincial hospital until such time as acceptable alternative arrangements can be made".

The HWO says this policy overlooks the fact that many people earn wages from which it is not possible for them to pay for the "privilege" of being cared for when they are sick.

Commenting on the reason given for the new policy — that the state wanted to cut down its health budget — the HWO said that while health costs were to be cut, the state "was prepared to maintain, at the expense of the taxpayer, the tricameral parliament structure and a fragmented health service at high costs".

HWO says that under the new system, hospital staff who were previously treated at no cost, are to pay hospital fees in cash.

They anticipate that many poorer people will delay seeking medical help until they are desperately ill.

Women's campaign

16/5/86 Sowetan 85

THE Imbeleko Women's Organisation is to launch a national campaign against the privatisation of health services, a Mamelodi seminar was told at the weekend.

The one day seminar also looked into the role of women in the struggle

By MOKGADI PELA

and in trade unions.

Delegates came from as far afield as Lenyenye, Kuruman, Langa in Cape Town and Ka-Ngwane.

Speaking at the seminar, the co-ordinator of Imbeleko, Miss Nomonde Jafta, said the struggle for national liberation and the struggle for women's emancipation had to run concurrently.

A speaker from the East Rand, Mr Mandla Nkosi, said by privatising health services the Government would follow the example of Ronald Reagan and Margaret Thatcher in their countries.

He said by introducing this law, black people would be forced to go to private hospitals which were expensive.

City's illegitimate birth-rate 45% — MoH urges State action

BY KAREN STANDER
Medical Reporter

NEARLY half the mothers who gave birth in Cape Town last year were unmarried and a third of the babies born in Western Cape Regional Services Council areas were illegitimate.

According to the annual report of the Cape Town City Council's Medical Officer of Health, Dr Reg Coogan, 2 800 teenagers gave birth last year and almost 2 300 were unmarried.

The most dramatic increase in illegitimacy was in the white population where the percentage has doubled since 1982. From four percent of white births in 1958, the percentage increased steadily until it reached 11,3 percent in 1986. Last year it leapt six percent to 17,2 percent.

In the coloured population the number of illegitimate births increased from 6 700 in 1986 to 7 100 last year, an increase of three percent to 43 percent. The percentage of illegitimate babies born to black, coloured and Asian women was 47,6 percent last year.

The overall percentage of illegitimate births in Cape Town last year increased by three percent to 45 percent.

No previous figures were available for teenage pregnancy but a breakdown of the ages of young mothers showed that 37 14-year-olds gave birth last year (two were married), 114 were 15 (seven were married) and 344, of whom 28 were married, were 16.

In the area served by the RSC, 58,1 of black births were illegitimate, 50,1 of coloured births, 7,2 of whites and 5,9 of Asians.

Deputy Medical Officer of Health Dr Stewart Fisher called for an intensive "lifestyle education" programme at schools which would include education on sex, Aids and other sexually transmitted diseases, as well as life-skills and how to handle teenage problems.

In an interview Dr Coogan said recession and unemployment led to a breakdown of social mores, including an increase in sexual promiscuity.

"It will take many years to redress the balance and counter the evils of unemployment and a lack of education and employment," he said.

The State had started an upliftment programme, but all that had been achieved in four years was a number of surveys.

"How many surveys do we need? How many more years will it be before they get down to the nitty gritty of providing houses for squatters and jobs for the unemployed?"

● **Homicide main cause of death in townships, page 2.**

Call for new approach in public health care

THE population explosion coupled with greater unemployment and insufficient economic growth were critical issues affecting health care, Pharmaceutical Manufacturing Association (PMA) president Hugo Snyckers said yesterday.

In addition, there was considerable misuse and abuse of private and public health-care schemes.

Addressing the national conference of the Pharmaceutical Society of SA, in Port

MICK COLLINS

Elizabeth, Snyckers said the problem was further compounded by an ageing white population — the demand for health care services by the aged exceeding their contribution, if any — and a large proportion of the black population being below 15 years of age.

"On top of this, the demand in SA on the fiscus has become unbearable because of other priorities — defence, housing and education.

"A fresh approach to finding a solution which will be cost effective, equitable and durable is, therefore, timely," Snyckers said.

"It is important to avoid implementing short-term decisions out of line with the philosophy to which SA subscribes — a private enterprise-based economy within which privatisation will play a decisive role."

● SNYCKERS

HEALTH SERVICES

The need to pull the plug

Our health services are in a sorry state. Despite gradual attempts to improve them, doubts linger about whether government has the stomach to carry out the necessary surgery.

On the surface, changes are coming thick and fast. Growing private-sector involvement in hospital and other services has resulted in tangible improvements. Having already successfully taken over the running of TB clinics and the care of geriatric and some psychiatric patients, private hospital groups are on the verge of managing entire State-owned hospitals.

Flexibility may soon be allowed in medical aid schemes so that members can choose the kind of cover they want. They could opt, for instance, to pay their own minor bills in order to allow for greater cover in the event of major illness or disability.

Rules are relaxing, too, in the services that doctors and pharmacists may provide and there is growing acceptance of the importance of generic drugs in keeping down overall medical costs.

But these — alas — are all cosmetic changes.

The biggest problem is the organisation of health services. The R2,9bn public health care budget is split between a bewildering assortment of departments. The Department of National Health is supplemented by three "own affairs" ministries and the day-to-day responsibility of running hospitals lies with the four provinces.

The health departments of the four independent and six self-governing homelands are separate. It's in this kind of fragmentation that the sickness lies.

Says National Health Director General Coen Slabber: "Health services are structured in the present form as a result of the constitutional dispensation." (That is to say, they are the result of apartheid.)

But Slabber argues that a centralised plan *can* apply. Government's "grand design" — its National Health Plan (NHP) — is intended to achieve this. "The NHP strives towards rendering a co-ordinated, efficient and balanced health service by centralised policymaking, centralised responsibility for the provision of health services and decentralised implementation," he says.

The major problem afflicting health care is fragmentation — insistence on ethnic categorisation of health services. This is slowly changing, particularly because of privatisation. But a serious shift in approach would appear to be reliant on political will, which is lacking.

One obstacle to such co-ordination is the existence of not one, but three co-ordinating bodies. The National Health Policy Council may look at the macro picture, but liaison with the homelands falls under the Regional Health Authority; while the provincial authorities meet in the Co-ordinating Board of Frovincial Administrators.

However, many of the NHP's specifics will be settled only after the Wim de Villiers Commission report on the issue is released at the end of the year.

The brief of the commission includes:

- ☐ Cost-effective privatisation of hospital services;
- ☐ Ways to lessen State involvement in health services;
- ☐ Reasons for the high cost of medicines and steps to overcome this;
- ☐ The role of medical insurance and medical schemes; and
- ☐ How to reduce State spending on health services generally through privatisation and deregulation.

The De Villiers report follows an earlier report by the Browne Commission. Tabled last year, it identified the main problems as excessive fragmentation of control over health services, lack of central policy direction, under-emphasis on preventive and primary care and over-emphasis on expensive secondary and tertiary services.

Slabber describes the NHP as a grand design — "striving for balanced deployment by co-ordinating services rendered by the three tiers of government."

A priority of any new health plan, according to officials, is to place more emphasis on community health.

There's no doubt that basic health education, particularly in rural areas, is often more important than the availability of sophisticated hospitals. Community clinics have made great strides in increasing awareness of how to avoid sickness and treat minor ailments. But even these good intentions are hampered by the biggest bugbear of health services — racial segregation.

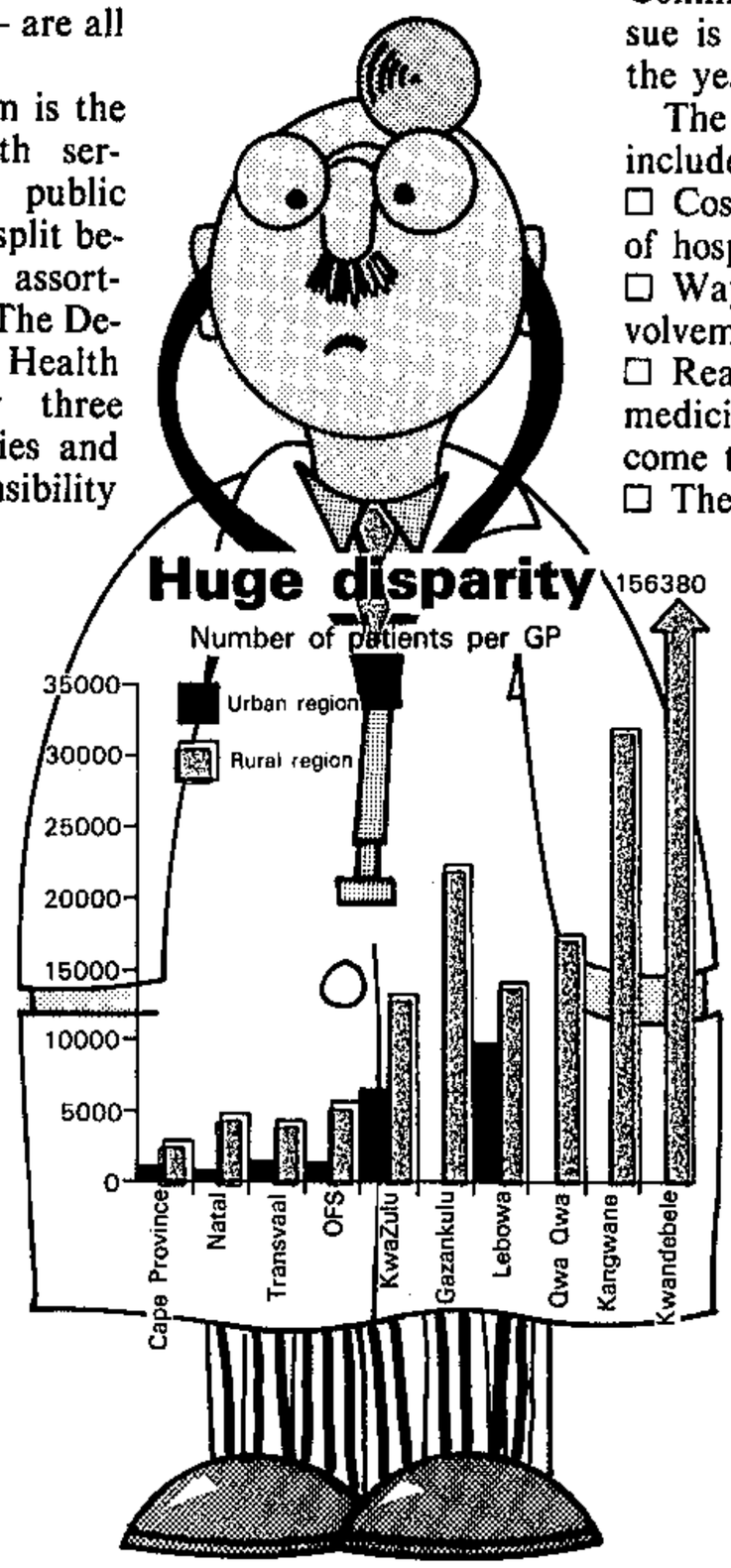
Cedric de Beer, a director of the Wits Centre for Health Policy Studies, says: "Often a small town will have four different clinics, with the same health care team moving from one to the other. Doctors in rural areas can spend up to two hours a day moving between segregated clinics."

The patient's view . . . and costs are as threatening

He adds that the ideals of the NHP aren't working on the ground. "Though giving homelands autonomy on health services may seem like rational decentralisation, it is anything but. When Shiluvane Hospital was transferred from Lebowa to Gazankulu, Lebowa built its own hospital 5 km away. The population would be better served if hospitals were more sensibly spread out. If there were a regional health policy for the northern Transvaal as a whole, such absurdities wouldn't take place."

According to Slabber, however: "It is a priority of the department to deploy health services in line with identified goals and not by simply shifting finances between various race groups, geographical areas and so on."

His attitude on integration is criticised by UCT sociology professor Michael Savage, who estimates the cost to the taxpayer of enforcing apartheid to be 12c in the rand. In



THE NATIONAL PARTY

And the band played on

Forty years on — and who could have thought in 1948 that the National Party-Afrikaner Party alliance, voted in by a minority of the white voters (41% against Jan Smuts's 51%), would have lasted to this day? Perhaps it is worthwhile asking why.

It has to be remembered that by and large blacks were consistently disregarded, barring the occasional war, by SA's rulers *until* the Afrikaner power axis gained ascendancy — and set about restructuring the entire economy to favour its voters' psychological and material needs. So racial segregation was hardly new in 1948. The natives were just out of social sight and not particularly restless.

What was new was that segregation became codified as never before, just as the world turned away from the practice, as it had from slavery in the last century. Along the way — and not without reason — poor Afrikaners became rich ones.

The world naturally looks on horrified at the abuse of human rights that arose in the process; it can be forgotten that the enormous bureaucracies spawned by apartheid amounted to a massive Keynesian experiment in decades-long make-work with predictable results.

The bill, comparable to a war debt, is endemic inflation — and is always paid by posterity. We, our children and our grandchildren, are that posterity.

That was the flaw in the Afrikaner revolution. Having finally wrested what, with some justice, they saw as their country from the hands of the rapaciously colonising English, they set about reinventing colonialism within the borders of SA itself. This meant positively inhibiting the prospects for rapid development; and, with that, an increasing concentration of wealth within the hands of a few with all this implies of political shiftiness and corruption.

The bantustans merely emulate the master state based in Pretoria — they were made in its image, that of ethnic divisiveness and rule through elitist civil services ultimately responsible to a clique, if not a single figure.

It is, of course, all coming unstuck. On page 45, we report on the likelihood of a new delimitation designed essentially to keep out the Conservatives (a method which historical consensus holds Smuts should have employed against the Nats rather than taking bows on the international stage). As a corollary, the NP aims to gather to itself English-speakers. This is a complete betrayal of its origins.

The Nationalists have also reversed themselves in other spheres: black may marry white, there may even soon be official suburbs for them to legally live in. The wonderful idea that if all the homelands could be induced to accept independence, there would be no black South Africans, has been abandoned, though not the Land Acts. The pass laws have gone — the police have other things to do.

However, these reversals — or reforms — have taken us back in time to the kind of society which might just have been passable in the Fifties, but not now. Revolution is not likely; neither is peace.

In the last round of serious "unrest" some zany, or prescient, comrades held that it was black girls' duty to fall pregnant: the birthrate would be what counted in the end. It is what these Mandela babies — so to speak — do with whatever power they can wrest from the Botha babies that will determine events well into the next century.

Perhaps it is because they have been contemplating that next 40 years that the NP leadership has seemed oddly subdued in celebrating its long, rather appalling reign. ■

MINISTRY OF MISINFORMATION

Come back, Eschel

A cornerstone of the NP's hold on power has been, if not exactly manipulation, at any rate, assiduous management of information flows and those sectors of the media it controls — notably the electronic one.

The philosophy that the only acceptable news is officially sponsored news ultimately means that no independent media can be tolerated — not even the Afrikaans press, as some editors have already learnt.

Van Wyk Louw's concept of *lojale verset* is long dead. Against this, we are not sure whether to laugh or cry at government's own recent news handling fiascos.

Consider:

☐ The Minister of Information unilaterally but disastrously attempted to introduce a new interest rate policy;

☐ A government publication has had to be withdrawn for fear "jocular" or "ironic" use of insulting ethnic descriptions might be "misunderstood"; and

☐ The Department of Information has established its own news agency, not to compete with the media but to put out "positive" stories for their use. The first was a harangue against pleas for clemency for the Sharpeville Six so emotionally worded that it, in effect, had to be disowned.

Of course, news manipulation is common even in democracies. Margaret Thatcher has practised it for years and is now seriously attacking the independence of the BBC.

But the chance of stifling dissenting views in such an open society is minimal. Here the danger is much greater. But, as thought control tightens, so the coherence of the message seems to dissipate to the extent of downright incompetence.

Connie Mulder had his faults. But at least, when he ran things, there was a singleness of purpose whose current lack is all too symptomatic of the NP's general loss of way. ■

MedAid spokesman Speedie ... the law encourages costly drugtaking

health care, the *FM* believes it is probably much more. For instance, there is the disparity in the ratio of patients to hospital beds and doctors (**see graph**). The notorious problems of overcrowding at Baragwanath and other black hospitals need no restating. Health care segregation has meant crowds at those hospitals — and hundreds of people sleeping on floors — and empty shells at their white counterparts. Johannesburg General has 2 000 beds — but only 833 are in use. Of 76 units, 17 are empty.

Hospital chief superintendent R J Broekmann blames this on a shortage of trained nursing staff and financial limitations.

However, manpower skills overall are often ineffectively deployed. At a time of critical nursing shortages at Baragwanath, there are 117 black nurses at Johannesburg General. Says Wits's De Beer: "While I would not wish to prevent black nurses working where they want, the underdeveloped black sector has been further impoverished by these movements."

The NHP doesn't properly address the problem of skills shortages. UCT professor Solly Benatar says the public sector is losing many of its best personnel both abroad and to the private sector. "Numbers conceal the problem. We are supposed to be experiencing a net inflow of doctors, but those who go are often experienced senior consultants; those who come in may have more basic experience.

"Under the present public-sector salary structure, top doctors are reasonably paid, but there is no visible advancing career structure. With brand new private hospitals opening, the attractions of the private sector are obvious and of overseas even more so."

Potentially, therefore, De Villiers' findings on privatisation could lead to far-reaching change — though such a process won't necessarily mean selling hospitals to the highest bidder. Indeed, Syncom executive director André Spier says large hospitals aren't a priority for privatisation.

"The most successful instance of privatisation so far has been the contracting out of services to organisations such as the Smith Mitchell organisation, including care for TB patients, geriatrics and non-violent psychiatric patients."

As with private hospital groups taking over the management, rather than ownership, of State hospitals, privatisation would lead to less State involvement in health care but not less responsibility. It should also be allowed to lead to better use of money.

According to Noristan pharmaceutical group MD Hugo Snyckers: "Instead of subsidising the institution and, therefore, paying money to people who don't need the subsidy, the individual patient should be subsidised."

Slabber says this is being investigated by the Office of the Commission of Administration and is certainly an option.

Another aspect being addressed by De Villiers is the high cost of medicine. Says Slabber: "The pharmaceutical manufacturer can play a significant role in containing costs, because the cost of any medicine on entering the distribution chain is determined by the manufacturer."

Medicines alone account for over 25% of medical aid payments.

SA Druggists MD Tony Karis says a potential area of saving is greater use of generic drugs, rather than more expensive original ethical products. "Medical aids should encourage prescribing doctors to use cost-effective medicine where possible, not the latest state-of-the-art antibiotic."

Some medical aids encourage generics through the Maximum Medical Aid Price, whereby a scheme refunds to the patient the price of the generic drug. The patient pays the difference if he opts for a more expensive ethical drug.

However, pharmacists may not replace an ethical drug with a generic equivalent without the express permission of the doctor. In a recent case, a pharmacist substituted a standard alcohol-based cough mixture for the ethical brand. The patient was an alcoholic and subsequently went back on the bottle.

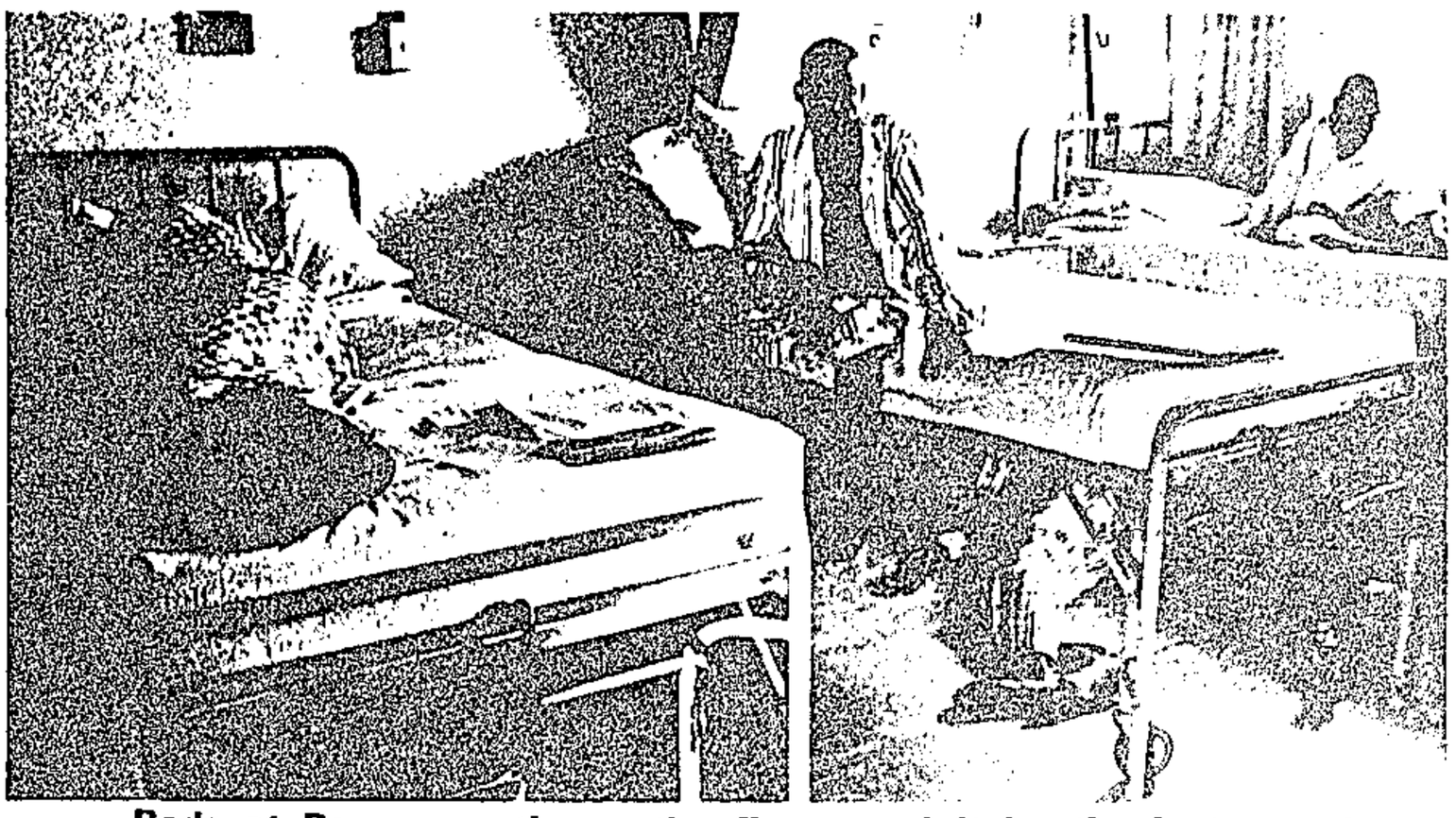
"Generic drugs are never identical to the ethicals they copy and there have been far too many instances of the pharmacist misusing substitution," says Dr John Cowlin, a strong opponent of generic substitution.

Implicit in government's talk of high medicine costs is the possibility of price control. But the Australian lesson should be noted: multinationals there pulled out — products and all — because of price control.

Whatever the case, there will be little disincentive to either the public or the practitioners not to waste medicines until the Medical Schemes Act is amended.

Says Representative Association of Medical Schemes executive director Rob Speedie: "Under the Medical Schemes Act, we have to offer first rand cover, which encourages the patient to use medical aid indiscriminately. For example, he will get a prescription when he could just as easily buy a medicine over the counter. Medical aid subscriptions are going up by an average of 25% a year." (**see graph.**)

Flexibility may soon be permitted. Subscriptions are currently fixed according to members' income and number of depen-



Beds at Baragwanath ... the floor needn't be the last resort

Language mediums

139. Mr R M BURROWS asked the Minister of Education and Culture:

What was the number of pupils taught through each language medium in all standards in each province for 1986 and 1987, respectively?

The MINISTER OF EDUCATION AND CULTURE:

Natal

	1986			1987		
	A*	E*	G*	A*	E*	G*
Gr (i)	2 587	6 330	75	2 573	6 369	68
(ii)	2 395	6 101	51	2 409	6 170	74
Std 1	2 542	6 182	52	2 301	5 982	38
2	2 565	6 354	49	2 479	6 110	41
3	2 949	6 518		2 493	6 216	
4	2 700	6 864		2 634	6 497	
5	2 674	7 137		2 609	6 810	
6	2 818	7 717		2 654	7 353	
7	2 771	7 735		2 651	7 642	
8	2 794	7 959		2 716	7 780	
9	2 337	7 264		2 506	7 461	
10	2 087	6 650		2 127	6 768	

Cape

	1986			1987		
	A*	E*	G*	A*	E*	D*
Gr (i)	10 991	6 904	6	11 416	7 077	7
(ii)	10 663	6 748	8	10 404	6 588	4
Std 1	10 652	6 600	9	10 455	5 574	4
2	11 202	6 822	8	10 723	6 581	8
3	11 123	6 989	8	11 149	6 762	8
4	11 226	7 268	13	10 811	6 888	5
5	11 317	7 556		10 062	7 075	
6	12 948	8 513		12 439	8 012	
7	13 129	8 864		12 688	8 308	
8	12 684	8 335		12 555	8 479	
9	10 472	7 236		10 693	7 344	
10	9 593	6 206		9 681	6 489	

Transvaal

	1986		1987	
	A	E	A	E
Gr (i)	29 332	13 145	30 751	13 046
(ii)	27 520	12 333	27 523	12 031
Std 1	28 185	12 533	27 204	11 817
2	28 533	13 183	28 117	11 914
3	29 689	13 878	28 592	12 646
4	29 917	14 254	29 453	13 152
5	29 504	14 478	29 622	13 494
6	31 195	15 645	30 863	14 511
7	31 134	15 481	30 525	14 946
8	29 504	14 333	29 430	14 122
9	25 381	12 308	26 731	12 813
10	22 857	10 297	22 802	10 664

OFS

	1986		1987	
	A	E	A	E
Gr (i)	5 601	594	5 567	623
(ii)	5 293	623	5 420	561
Std 1	5 344	610	5 277	641
2	5 426	630	5 268	612
3	5 517	668	5 386	634
4	5 593	661	5 475	681
5	5 272	706	5 371	635
6	5 965	597	5 409	804
7	5 890	588	5 567	719
8	5 686	562	5 563	706
9	4 954	486	5 058	647
10	4 333	427	4 351	539

*A = Afrikaans E = English G = German

Engineering students/staff

140. Mr C J DERBY-LEWIS asked the Minister of Education and Culture:

(a) How many (i) White, (ii) Coloured, (iii) Indian and (iv) Black engineering students are currently registered at each university falling under his Department, (b) (i) how many persons are attached to the academic staff of each engineering faculty and (ii) what is the total cost involved in each case and (c) in respect of what date is this information furnished?

The MINISTER OF EDUCATION AND CULTURE:

(a) Number of full-time-equivalent students

	(i)	(ii)	(iii)	(iv)
Pretoria	1 315	—	—	—
Witwatersrand	944	7	25	62
RAU	153	1	—	—
Potchefstroom	171	—	—	—
Natal	512	8	68	38
Stellenbosch	703	16	2	—
Cape Town	630	55	13	46

(b) (i)

Pretoria	82
Witwatersrand	58
RAU	20
Potchefstroom	33
Natal	32
Stellenbosch	49
Cape Town	58

(ii)

Pretoria	R4 491 000
Witwatersrand	R2 869 000
RAU	R 695 000
Potchefstroom	R1 754 000
Natal	R1 471 000
Stellenbosch	R2 304 000
Cape Town	R2 149 000

(c) 1986.

Pupils: medical inspections

142. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether any schools under his control are visited by medical inspectors for the routine medical inspection of pupils; if not, why not; if so, in respect of each province in 1987, (a) how many schools were so visited, (b) what total number of pupils was examined and (c) what was the percentage of pupils examined in comparison with the total pupil population;

(2) whether any pupils requiring medical treatment were referred for such treatment; if not, why not; if so, in respect of each province in 1987, (a) what was the total number of pupils so referred and (b) what number of pupils was referred for nutritional and related reasons?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes,*

	(a)	(b)	(c)
Cape	232	26 783	11,9
Natal	207	24 316	19,6
OFS	292	37 763	50,8
Transvaal	1 145	433 639	83

(2) yes,

	(a)	(b)
Cape	4 053	242
Natal	2 951	255
OFS	6 037	7
Transvaal	12 315	1 206

*In the OFS the service was rendered by school nurses since the post of medical inspector could not be filled.

White teachers: surplus

144. Mr C J DERBY-LEWIS asked the Minister of Education and Culture:

Whether there is a surplus of White teachers in the Republic; if so, (a) what is the extent of the surplus and (b) what steps are being taken by his Department in this regard?

The MINISTER OF EDUCATION AND CULTURE:

Yes, in certain regions, although shortages occur as reflected in my answer to question no. 130 of 24 May 1988,

(a) the exact extent of the surplus is not known since registered teachers may be employed elsewhere or may prefer not to teach at present;

(b) a number of steps are taken. These include the recording of vacant posts and teachers who are available, as well as the further training of teachers for scarce subjects.

Primary school pupils: reading ability

145. Mr C J DERBY-LEWIS asked the Minister of Education and Culture:

(1) Whether it is possible for pupils attending primary schools falling under his Department to be promoted to high schools without their being able to read fluently; if so, under what circumstances;

(2) what are the minimum requirements for promoting pupils from primary to high schools?

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, although emphasis is placed on reading in the primary school, such pupils may pass if their other language skills allow them to obtain the required pass mark;

(2) the minimum promotion requirements for Std 5 are as follows:

Transvaal

(a) a pupil must pass both official languages with at least an E symbol in each,

(b) if all 7 subjects have been passed, at least 2 D symbols and 5 E symbols must be obtained,

(c) if 6 subjects have been passed, at least 3 D symbols and 3 E symbols must be obtained,

(d) if 5 subjects have been passed, at least 1 C symbol, 2 D symbols and 2 E symbols must be obtained.

Natal

(a) *Promotion to standard 6 to take all subjects on the Standard Grade*

pupils who obtain a minimum of 40%

Health workers act on new tariffs

CP Correspondent

DURBAN'S Health Workers Organistion has launched a campaign against increased hospital fees.

The organisation as distributed information leaflets instructing patients on how to complete assessment forms and how the tariff increases operate.

They have also urged people to petition against the increases. Patients have been urged to refuse to be turned away from racially-restricted hospitals.

"Health is a right. We demand free health care and that no one be turned away from hospital.

"We demand one health department for all and that people be consulted about hospital fees," the organisation added.

We are independent, says Masa head

The Medical Association of South Africa (Masa) has been repeatedly criticised for its apparent support of apartheid and its failure to respond to the detention of children in this country. However, Dr Sholem Kay, Masa president, last week fiercely defended the association, saying it had fought for many years against racial discrimination. ***Toni Younghusband, The Star's Medical Reporter, writes:***

The president of the National Medical and Dental Association of South Africa (Namda), Dr Diliza Mji, last year accused Masa of being an integral part of apartheid.

He said during a trip to the United States that white South Africans enjoyed a health status comparable to the best in the world while blacks were exposed to health conditions similar to those in some of the poorest countries in the world. He accused Masa of "failing to condemn" the mass detentions that took place in South Africa during the state of emergency.

And in the British medical journal *The Lancet* an April article on child detentions in South Africa blamed this country's official medical bodies of never having made an adequate response to the detentions.

Dr Sholem Kay hotly defended the association at Masa's annual congress last week.

'NOT CONNECTED WITH GOVT'

He said it was a non-partisan independent professional organisation "not connected in any way with the South African Government, the South African Medical and Dental Council nor any other statutory bodies".

Dr Kay said Masa dedicated itself towards providing the best possible health service to all, was totally non-racial and had "fought for many years against racial discrimination in medicine".

He pointed out that Masa had been instrumental in obtaining equal salaries for all racial groups and the formation of panels of its members who could be called on by district surgeons as a second opinion when requested by detainees.

"There are many other ways in which Masa assisted those in need but it is not always tactful or diplomatic to publicise what we have accomplished. Suffice to say, we have never ignored a cry for help," he said.

Dr Kay said Masa had been particularly active in addressing the problems currently plaguing academic hospitals.

"There are many problems in the provision of health care in South Africa but I can assure you that Masa will continue to do its best to help solve them so as to ensure good health care for all the people of this country," he said.

Masa concern over detainees

GERALD REILLY

PRETORIA — The Medical Association of SA (Masa) federal council has called for legislation to ensure detainees have access to a Masa panel of doctors.

Federal council chairman Bernard Mandell said Masa was concerned over allegations of detainees not being given access to the panel for second opinions.

The federal council also wants all medical graduates regardless of race or sex to serve two years of obligatory national service, either in the SADF or in community posts in "under-doctored" areas and institutions.

Mandell said full registration by the SA Medical and Dental Council should be accorded only on completion of the service.

Medics call for health rethink

GERALD REILLY

PRETORIA — The Medical Association of SA (Masa) has condemned the fragmentation of health services resulting from the implementation of the new constitution.

Masa federal council chairman Bernard Mandell said fragmentation led to costly duplication and even triplication of professional staff resources.

This would continue unless steps were taken to see the position was reversed.

"Masa is unfortunately obliged to involve itself in politics but since politics are interfering with health services this is justifiable."

It was important to realise that diseases recognised no barriers.

Doctors in private practice who dealt mainly with the first three levels of health had to liase with five different health authorities within the same community, the various administrations of the Houses of Assembly, Delegates and Representatives.

They also had to deal with the Department of National Health and provincial administrations.

"This is conducive to friction, red tape, time wasting and ineffectiveness," Mandell said.

Masa favoured a unified health system where all components would be closely linked and integrated. This would ensure a more cost effective and more efficient service for more people.

Mandell said there was much to be done to counter the effects of fragmentation.

Vlok wrong says Namda

THE National Medical and Dental Association has denied Mr Adriaan Vlok's claim that there were no children in detention.

Mr Vlok, who is the Minister of Law and Order, has according to Namda, also produced birth certificates of the children in detention to prove his denial.

The Minister was reacting to a former Detainees Parents Support Committee official, Dr Max Coleman's allegations that there were children in detention.

Proof

Namda said it was running a detainees service. It said: "During the period January to May this year, we have seen three ex-detainees between the ages of 10 and 14, 13 between 15 and 17 and 37 detainees between the ages of 18 and 20."

In Durban, Namda said, five former detainees between the ages of 15 and 17 and 10 between 18 and 20 were examined.

"This in itself is adequate proof that the South African Government has no aversion to detaining children and this makes us doubt the accuracy of the statements by Mr Vlok," Namda said.

SQUATTERS PLIGHT

Sowetan 14/6/88

HEALTH 2000 conducted a survey at the Chiawelo emergency camp at the weekend.

Dr Abu Asvat, co-ordinator of Health 2000, said: "We found that there were 25 families living in tents with no end of their plight in sight.

"The threat of removal to Rietvallei still looms large on them. Therefore few people have money for brick structures. They also feel that the R27 they pay for rent is exorbitant," Dr Asvat said.

Many cases of upper respiratory problems were found as a result of the recent cold spell and poor quality of their structures, he said.

Health 2000 found a number of cases of previously undetected high blood pressure and referred them to the Chiawelo clinic.

They also found a case of one teenage mother who had no source of income and having two underfed children. She was referred to the social workers for assistance.

Dr Asvat said they distributed soup and bread as well as clothes obtained from well wishers. Health 2000 also made a call to the community to bring along old clothes and blankets to house No 2065 at Moroka, Soweto for distribution.

SAVED FROM STARVATION

By ANTHONY DOMAN, Municipal Reporter

THOUSANDS of stricken families fighting "increasing hunger, malnutrition, distress and despair caused by grinding poverty" have been saved from disaster by The Argus Food Campaign, says Medical Officer of Health Dr Reg Coogan.

The campaign, operated through the Mayor's Relief Fund, is a "unique exercise in community health", said Dr Coogan in his 13th and final annual report — he retires this year.

After Government food parcels proved inadequate to cope with people suffering from "grinding poverty and the lack of job opportunities" in early 1986, the campaign took over "most successfully".

It brought relief to thousands of stricken families and the "genuine gratitude and goodwill generated" were enormous. Contributions from industry, the business sector and people in general were "excellent".

The Argus had been of "enormous benefit" to the fund, particularly reminding readers of the existence of the campaign.

At the time his report was written the total had reached more than R400 000.

"Our many generous contributors can take comfort from the fact that, during this recession, no needy family in the city will starve while we can prevent it," said Dr Coogan.

Other major points in his report were Cape Town's success at lowering its infant mortality rate, its joint nuclear accident exercise, and the battle against air pollution, Aids and tuberculosis.

The infant mortality rate had been halved in 12 years to 17,84 deaths in every thousand, he said. According to World Health Organisation criteria, between 10 and 20 was acceptable for a city of the developed Western World.

Cape Town's figures were the best in the country, he said.

On nuclear accident readiness, he said the combined nuclear accident exercise held by the Atomic Energy Corporation, Eskom and the City Council came after "nearly a decade of intensive argument with the nuclear establishment".

It would be necessary to hold at least another three exercises to cover all of the city, he said.

Small nuclear accidents could be handled with a trained populace but a major accident would present "overwhelming difficulty".

Dr Coogan sharply criticised the fact that the operator of the plant was designated Emergency Controller; this presented an "obvious conflict of interests".

Turning to disease, Dr Coogan said tuberculosis was the biggest public health problem in Cape Town.

Distressing

Studies had shown that the shortage of housing, leading to gross overcrowding, was a major cause of the spread of infectious conditions such as TB.

"It is distressing that no significant progress has been made in controlling TB," he said. "It is not possible to eradicate it by medical means alone."

One "grave error" was the closing of more than 1 000 treatment beds between 1975 and 1980. Treating TB sufferers as outpatients was "cent wise, rand foolish and was storing up a lot of trouble for the future".

In Cape Town only one bed was available for every 25 cases — compared with the national ratio of one in five.

Dr Coogan urged swift action to combat Aids. It was estimated that more than 1 000 persons in the Western Cape were positive for the HIV virus, and these people were potentially infectious to others.

Black health care comes under the spotlight

By ZB MOLEFE

WHOSE responsibility is health and social welfare in South Africa – the State or the private sector?

These are some of the questions the Centre for Enrichment in African Political Affairs will try to answer in a two-day Soweto seminar later this month.

Among the speakers will be Coronation Hospital consultant Joe Variava and acting co-ordinator of the Witwatersrand network for the homeless, Ishmael Mkhabela.

Also speaking will be SA Council of Churches home and family life director, Fikile Mazibuko and Soweto general practitioner Jubilee Kgomo.

The seminar will highlight the issue addressed by the SA Institute of Race Relations in its *Update* publication earlier this year, that black access to adequate health facilities appeared to be declining in the last quarter of 1987.

"The need for public health services' was outsripping the government's willingness to fund them," said *Update*.

In a detailed examination of health services, the publication quoted official spokesmen saying that while they were committed to improving black health services, they could not because funds were not available.

The publication also quoted a health researcher who said black patients found it difficult to obtain public transport to health care facilities during working hours.

Discussing desegregation of public hospitals, *Update* reported that of the 17 unused wards at Johannesburg Hospital, three were being converted into accommodation for trainees at white nursing colleges.

And the rest were not being used due to a "staff shortage and lack of funds", according to Health Minister Willie van Niekerk.

Although this hospital was intended primarly for white patients, between January 1, 1986, and August 31, 1987, 324 black and 65 Indian and coloured patients underwent cardiothoracic sugery there, compared with 206 whites.

About 26 percent of kidney transplants at the hospital were performrd on black patients. Last year 28 674 black, 1 468 coloured people and 477 Indian patients underwent radio therapy at the Johannesburg Hospital compared with 17 156 whites.

In some cases patients were referred tc Baragwanath Hospital, *Update* said.

Pressure on the government to improve black access to health care was bound to grow, the publication pointed out. This would be the result of the likelihood of private health becoming out of reach for most blacks.

"While government was looking increasingly at the privatisation of hospitals as a solution to the problems facing it, the attempt to reduce the State's responsibility for health care was eliticing fierce opposition from doctors and critics.

"They charged that the public health service was deterioriating sharply and was increasingly out of reach of low income earners," *Update* said.

Rams, Masa hold discussions

THE cost of medical care has become prominent once again as the two major forces in this field embark on a series of discussions on medical aid structures.

The Representative Association of Medical Schemes (Rams) and the Medical Association of SA (Masa) have agreed urgent steps are needed to reduce or prevent the inflationary effects of over-servicing by doctors and over-use by medical scheme members.

However, the two organisations are at odds about how the problem should be solved.

Rams executive director Rob Speedie says Masa is reported to have said if medical scheme members were made to pay a portion of the costs of medical treatment — over and above what their medical schemes pay — they would use the benefits more responsibly.

"After careful consideration, Rams has decided to reject the Masa proposal that doctors be allowed to charge what they like for services, while still enjoying the 100% guaranteed payment from medical schemes in terms of the Rams scale of benefits," says Speedie.

LIZ ROUSE

(85) B/day 20/6/88.

Outrage over delay on skin cream ban

Star 1/7/85

South Africa's multimillion-rand skin lightening industry has been granted a three-year reprieve. A Government ban on skin lightening products, which was to have come into effect today has been postponed to 1991, despite strong opposition from consumer organisations and the medical profession. *Toni Younghusband, The Star's Medical Reporter*, looks at the issue.

The skin lightening industry controversy stretches back to when women's organisations and medical experts first called for these products to be banned more than a decade ago.

Reports in medical journals warned that extended use of the preparations could cause severe and irreversible damage to the skin.

After an initial bleaching effect, lasting two to three months, the skin darkens. It becomes coarse, with small raised bumps which eventually join together to form larger raised areas.

These changes are permanent and irreversible, says a report by leading University of the Witwatersrand dermatologist Dr Hilary Carman.

An ingredient called hydroquinone is the culprit agent in the creams.

In 1982, South Africa limited the concentration of hydroquinone in cosmetics to two percent. But, says Dr Carman, there is strong evidence that, even at a concentration of two percent, hydroquinone continues to cause damage.

After relentless pressure by consumer groups and medical researchers, the Department of National Health and Population Development announced that, on July 1, all products containing hydroquinone would be banned.

But, only months later, this decision was reversed and the ban postponed to 1991.

Campaign

The Minister of Health, Dr Willie van Niekerk, said there were legal, financial and health considerations to take into account. He said the postponement would allow manufacturers a "phasing-out" period.

The Black Consumers' Union (BCU) has accused the Government of insensitivity and said that, if the product had been for white consumers, the issue would not have been allowed to go so far.

The BCU is to launch a campaign against skin lighteners later this month.

Medical experts have also expressed their disgust at the Government's turn-about.

Dr James Phillips, of the South African Institute for Medical Research, said there was not a "shred of medical evidence" to show that skin lighteners were not harmful.

"These lotions should be banned now. But they are not and the onus lies with the manufacturer to prove these products are safe," Dr Phillips said.

He said he believed it was not loss of production which the manufacturers feared most but rather a risk of litigation.

"If these products are banned it would be easy for someone to take a test case to court and win. Then you'd have thousands of people who had suffered with these creams doing the same and this would put the manufacturers out of business," he said.

A memorandum submitted to staff at one manufacturing plant said that after representations had been made to the Minister of Health it had been decided that skin lightening creams would be re-classified to fall under the Medicines Act. They are now registered as cosmetics.

Millions

Pharmacists have protested angrily.The Natal Wholesale Chemists Group has refused to stock the products and two major supermarket chains will not sell them.

The skin-lightening industry is believed to be worth about R80 million a year and employs thousands of people. Leading South African corporations have shares in the companies which manufacture the lotions.

The financial implications of a ban and the loss of employment are obvious. So, says the medical profession, is the evidence of irreversible disfigurement these creams cause.

Financial health the HMO way

Dr John Cowlin recently co-wrote a report on Health Maintenance Organisations (HMOs) for the Department of National Health. Here he summarises the arguments in the report

Much has been written about health care privatisation in SA. Given the size of the cake the SA taxpayer is expected to fund, I don't believe government has any alternative.

About 20% of the population — that's 6m people, mostly whites — are covered by medical aid schemes. Generally speaking, the standard of health care which medical aid insurance provides is excellent. So patients covered by medical aid have nothing to fear from health care privatisation.

Health Minister Willie van Niekerk has said the State can no longer afford to subsidise non-medical aid health care, and employed South Africans should look to the private sector to provide these facilities. Furthermore, if the private sector could provide health care to indigent and unemployed South Africans at a lower cost than the State, it would be prepared to subsidise the private sector on a per capita basis.

Government clearly intends to transfer provision of health care for non-medical aid employees from the taxpayer to the employee and his employer.

Given rising expectations, higher real incomes and increasing industrialisation of black workers, their health care needs are going to escalate in the near future. Already, organised labour is making demands on management to provide health care insurance for workers.

Understandably, the health care industry recognises a great opportunity. The primary challenge, however, is not simply to provide facilities, but affordable and cost-effective ones. What these systems need are the following:

- ☐ To provide primary health care and common surgical procedures;
- ☐ Sophisticated procedures can be referred to existing provincial or private facilities;
- ☐ They must be affordable;
- ☐ More emphasis on preventative medicine; and
- ☐ Health care professionals, such as doctors and nurses, must be allowed to share in savings created by cost-effectiveness, as an incentive to do so.

I believe the HMO concept, with certain modifications, will fulfil the above criteria.

Briefly, a HMO is a health care system in which the only source of revenue is a predetermined monthly subscription. HMOs are encouraged to practice cost-effective medicine as they cannot spend more than their total subscription revenue on health care.

In the US, HMOs currently finance about 10% of health care insurance needs. It has been shown that they can reduce health care costs by 45%, compared to conventional medical aid schemes. They may have an elitist connotation, but this should not detract from the fact that they provide cost-effective health care.

Any excess of income over expenditure can be distributed to doctors and nurses as a bonus for cost-effectiveness, as well as to provide dividends for financiers and shareholders.

Alternatively, such excess of income can be redistributed to members of the scheme by means of no-claim bonuses on future premiums.

Such an arrangement provides an effective deterrent against over-servicing by both patient and doctor.

Current SA legislation does not prohibit HMOs as such, as the Registrar of Medical Schemes is empowered to exempt any medical scheme from all or any of the provisions of the Medical Schemes Act.

It is in the ethical rules of the SA Medical and Dental Council that the greatest stumbling blocks exist.

These rules prevent group practice and advertising on the part of doctors, as well as doctors being employed for another person or institution's gain.

However, the vacuum created by State withdrawal from health care provision must be filled by more cost-effective, imaginative and flexible health care systems.

The Medical Council's ethical rules are adapted to a largely First World and "Harley Street" medical environment. SA faces a health care crisis which requires that these ethical rules be amended to allow health care systems such as HMOs to function.

Under existing medical aid schemes, a family of four would pay about R240 a month in subscriptions. Most South Africans cannot afford such a premium. Many black workers, however, with a 50% subsidy from employers, could afford a R60 a month premium to a HMO.

Government has decided to privatise — now let it remove outdated restrictions placed on the health care insurance industry.

The Ladies of the Lamp on the move

By THABO THULO

DURBAN. — A wave of discontent is sweeping the nursing profession in private institutions.

Hospital wards are turning into a battleground of sorts, while overworked nurses fight fiercely for a living wage and reasonable working conditions.

Conflict between nurses and private hospitals has reached fierce levels. Police have been called in, on occasion, to quell the zealous militancy of the nurses.

And nurses have discovered the value of unionism to consolidate their fight against officialdom.

Now the nurses are joining the National Education Health and Allied Workers Union (Nehawu) and its ally, the Health Worker's Organisation (HWO), in greater numbers. But this has stepped up conflict between nurses and employers.

With pride

Conservatism and humility, traditional virtues in the nursing profession, are being discarded by militant "ladies of the lamps".

This stance has been aptly portrayed in a placard used by demonstrating nurses in Canada:

Florence had a little lamp

She carried it with pride

But when she saw her pay cheque

Even she sat down and cried

Florence Nightingale's legacy of long hours, no complaints and obedience to superiors is now a big issue in modern nursing.

One of the most serious problems so far stems from the contradiction between a pledge started by Florence more than a century ago and the Labour Relations Act following recommendations by the Wiehahn Commission in 1977.

Join unions

According to the pledge, a nurse regards the interests of the patient as primary, irrespective of status and religion.

On the other hand nurses working for private institutions, unlike their counterparts in public institutions, are covered by the Act and are catered for by the industrial court. This allows them to join unions, and the right to strike and to enter into agreements which may include working conditions and wages.

Crises in the nursing profession seemed to deepen this month as more nurses in the country's private hospitals — who at one stage or another took part in a work stoppage — were charged by the South African Nursing Council (SANC) for improper and disgraceful conduct.

The latest to receive summonses are about 200 nurses at Durban's John Conradie, Farrer and Southern houses, all old-age homes owned by The Association for the Aged (TAFTA).

Downed tools

They downed tools with other staffers for six hours in April after accusing management of delaying tactics to avoid a meeting on recognition, salaries and working conditions.

Natal Settlers Home nurses were the first to receive summonses last month, a year after 152 staffers downed tools in demand for higher wages and better working conditions.

Those summonsed are accused of refusing, or deliberately or negligently failing, to execute their lawful duties when absent from work without authorisation.

This case has been postponed to August 8 to allow the SANC to investigate new evidence from the nurses.

A National Education Health and Allied Workers Union (NEHAWU) spokesperson said the nurses pointed out that before downing tools they sought help, in vain, from the South African Nursing Association (SANA).

SANA's aims include promoting the status of nurses and improving health care, but NEHAWU is in possession of correspondence showing that Durban's Bill Buchanan Old Age home had retrenched assistant nurses and replaced them with wardmaids.

As wardmaids are not trained, it makes economic sense to use them instead of assistant nurses. One assistant returned from sick leave and was told by management that her post as a nurse had expired but she could be rehired as a wardmaid.

The nurse said she sought help from SANA, which said it could not help her.

According to a NEHAWU spokesperson: "In such cases SANA should intervene for the process is not only demoting nurses, it is also lowering the standard of health care."

A pre-planned interview with SANA was cancelled at the last moment and the writer was referred to a Pretoria-based labour sociologist, who could not be contacted.

Aerobics

A journal, Nursing in Natal, found that nurses problems and grievances were not being addressed. But the official SANA journal instead focused on an aerobics marathon, a choir competition, a Kwazulu-Natal Indaba video presentation, and various discounts for nurses.

The standard of food is a major grievance among nurses throughout the country and is the reason for the recent disturbance at Thembisa Hospital, outside Johannesburg.

In Bloemfontein food is cooked at a white hospital in town, packed into small boxes and transported to Pelonomi Hospital, a major training centre for student nurses from as far afield as Namibia.

Asked whether the food reached them still fresh, one nurse replied with a question: "How do you tell if food is fresh, especially food that has been cooked, frozen and re heated again?"

A prominent Port Elizabeth doctor has called for a commission of inquiry into the shortage of nurses in provincial hospitals.

Disastrous

In a letter in the June edition of the SA Medical Journal he said the shortage had reached "disastrous proportions". He called on the government to reconsider privatising medical services as most South Africans could not afford large scale privatisation.

He ascribed the national shortage of qualified nurses at provincial hospitals to several reasons, including the expansion of private hospitals, working conditions and salaries.

Port Elizabeth Provincial Hospital has about 130 empty beds due to the staff shortage.

A National Medical and Dental Association (Namda) spokesperson said Durban's Addington Hospital had the same problem, while the larger hospitals were also overcrowded. He cited Soweto's Baragwanath and Durban's King Edward VIII as examples.

One of the peculiarities of privatisation is that while it drives nurses away from provincial hospital, the lower fees attract more patients, increasing pressure on the remaining nurses, which the HWO blames for mistakes like nurses administering incorrect medicines with serious consequences.

Big companies

SANA's statistics show that last year — in Natal alone — there were nine inquests involving 40 nurses.

Qualified nurses are in high demand among big companies where they are employed in various food and heath care projects.

A Soweto driving school owner recently told reporters his business was booming as nurses prepared themselves to drive company cars. The trend is being established in all the major cities.

The Ladies of the Lamp are on the move.

Queuing for a measly pittance

THEY wait from the early hours of the morning for their pensions. Some even sleep outside the payment centres every two months.

But the pittance they get is hardly enough to see them through.

For African old age pensioners, some pictured on this page, there is no hope of retiring gracefully.

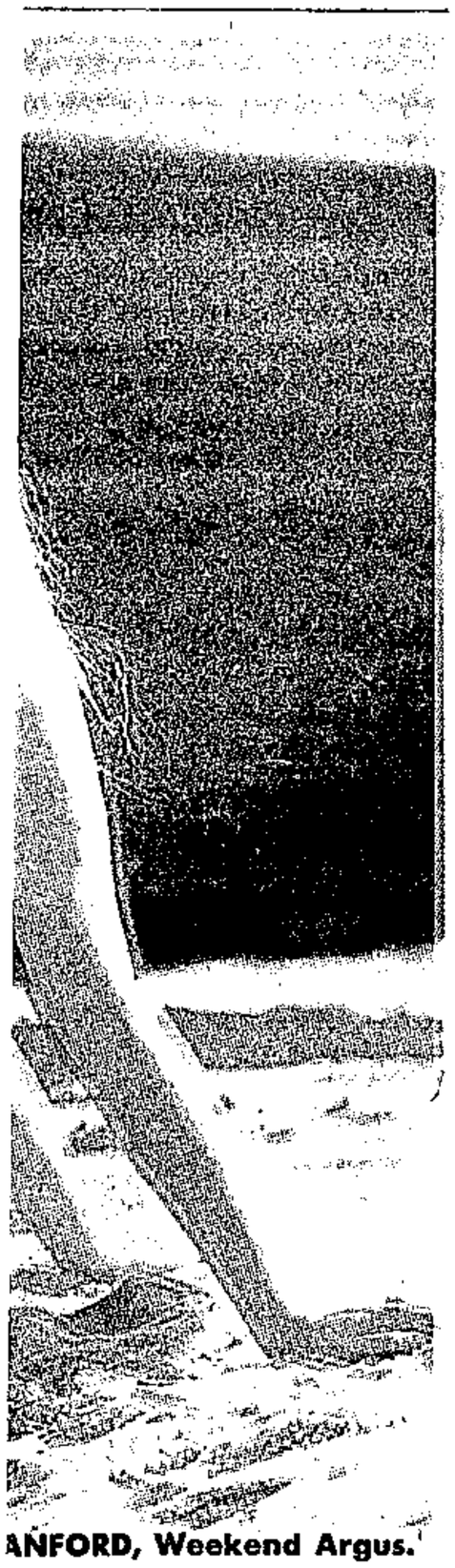
They will have to continue with the same routine every two months until they die.

PICS: FANIE JASON

28/7 - 4/8/88 South

85 w/c ARGUS 6/8/88

...ast 'hite' Red Cross ...aos ...world expulsion



ANFORD, Weekend Argus.

...the strong, insistent ...h the Western Prov... ...ne and would like to ...wn for her swimming ...JCT student keeps in ...e of the world's top

Picture: LEON MÜLLER, Weekend Argus

...er Victoria Sihau, left, and Tutu Gcememe, community or... ...ga, help pensioner Mr Lenox Lumbe to a Red Cross vehicle. ...es performed by the society is fetching sick or disabled pen... ... their homes and taking them to fetch their pensions.

fight the South African government, to attack them on any policy. Our responsibility is to care for anyone suffering, whether as a result of political violence or floods.

"It is essential for us to be free to operate throughout the society."

Mr Patterson said although they were taking the threat to expel the society seriously, "we will not sink to counter-accusations".

"We are not taking counter-action, although we would very much like our critics to come here and see our work."

Mr Patterson said it was the South African government delegation and not the South African society which was barred from the International Conference in 1986.

The conference, held every four years, is attended by the Swiss International Committee of the Red Cross (ICRC), delegations from all national societies and from governments which are signatories of the Geneva Conventions.

He said there was no procedure for the suspension of a member of the international conference, but the motion to expel could be forced through if the chairman was sympathetic.

The other international body of the Red Cross movement is the League of Red Cross and Red Crescent Societies, a working body of the national societies and which deals with common problems.

Mr Patterson said a national society could be suspended from the league, but only after a commission of enquiry.

In the 1970s there had been an attempt to query the credential of the South African Red Cross and a commission was appointed. However, when the commission had called for complaints which they could investigate, none were forthcoming.

No state funds

"The South African Red Cross is totally against racism in the organisation and outside. We do not practise it in our hiring or our hierachy.

"We do not receive money from the government, except for low-interest loans or grants for specific services which any other organisation doing the same work could also get.

"The International Committee of the Red Cross's permanent delegation in South Africa is here at the behest of government. It can't force its way in. And the Red Cross cannot be one-sided if it refuses access. The SA government allows access to detainees only after they are convicted. In that we are under their control.

"In 1986 the government was grossly insulted by its suspension from the International Conference. It retaliated by withdrawing permission for ICRC to be here, but this decision was rescinded three weeks later."

Mr Patterson said this kind of campaign had an enormous negative effect on the entire Red Cross movement.

"It creates doubt about our ability to perform the job."

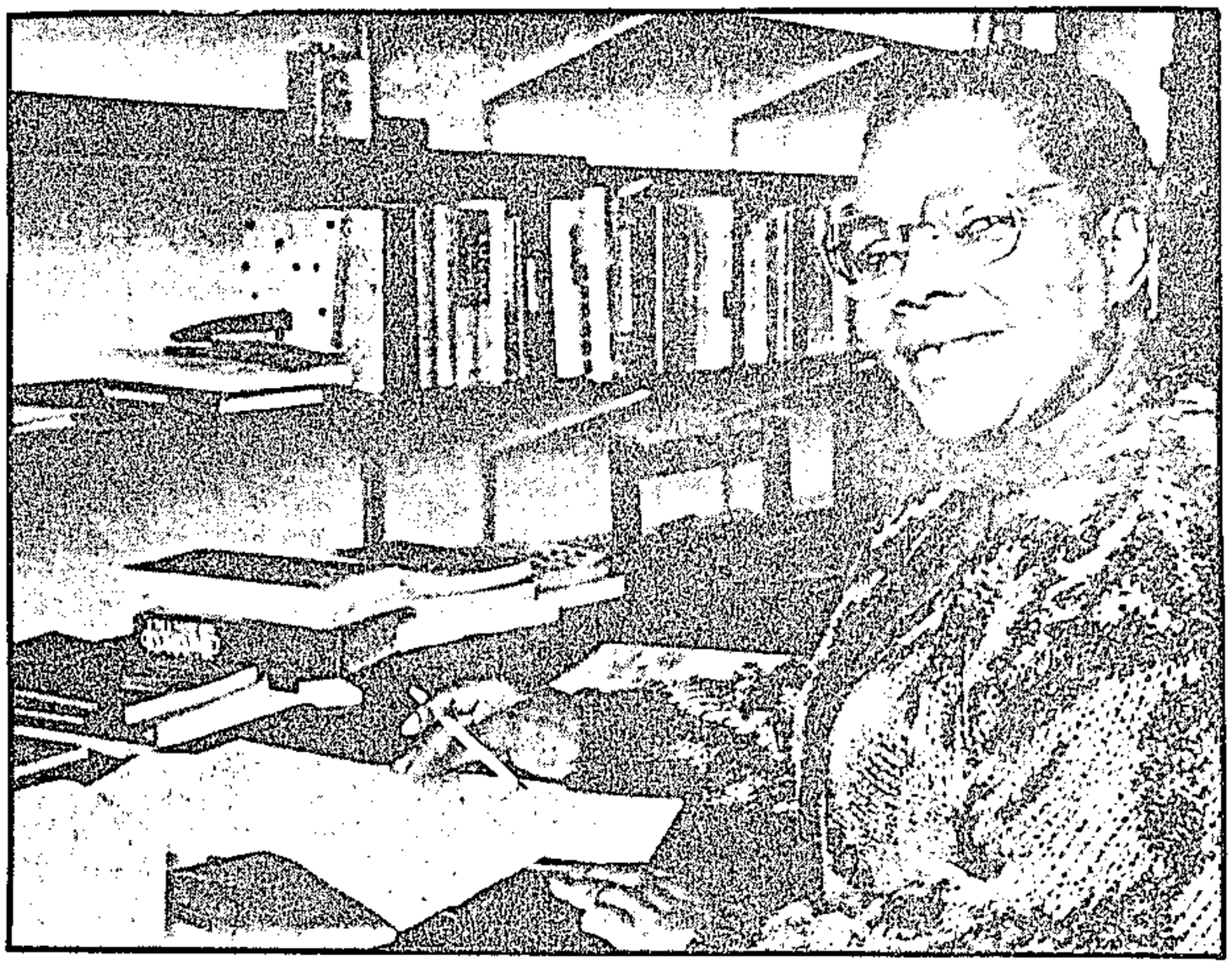
Weekend FOCUS 1

PROFESSOR Harriet Ngubane is a distinguished anthropologist. She recently addressed a Medical Students' Council conference on medical practice meeting the needs of the individual and the community. Her subject is traditional medicine.

A healing tradition

The UCT professor with the understanding touch . . .

by GORRY BOWES-TAYLOR
Weekend Argus Reporter



Picture: PETER STANFORD, Weekend Argus.

PROFESSOR Harriet Ngubane, talking on traditional medicine: "We're not saying either is better, just that there are differences."

"IT'S ironic," she says, "that I had to leave Natal university in the '60s when the government wouldn't allow blacks in white universities."

Now she is the first black full-professor at UCT, appointed in 1986. An important part of her job is to advise the Vice Chancellor on making UCT comfortably multiracial.

Professor Harriet Ngubane is a distinguished anthropologist. She recently addressed a Medical Students' Council conference on medical practice meeting the needs of the individual and the community. Her subject is traditional medicine.

In the Arts block at UCT her room is warm, the walls are lined with learned books though her own, *Body and Mind in Zulu Medicine*, is not among them. "Oh isn't it?" she says, "but I must have a copy at home." And she scribbles on a nearby pad indicate that she is writing another.

Her PhD is from Cambridge (she was at the glorious Lucy Cavendish College), and she has lived and worked abroad for 20 years. She was a fellow at St Anne's, Oxford and taught at Edinburgh University.

In England she was also recruited into the Ministry of Overseas Development to advise on certain sociological issues, a job which brought her back to Africa, to Swaziland and Lesotho. Then a two and a half year stint with the UN's International Labour Organisation. "All that was fantastic experience," she says. "And at the end of it you feel: My goodness if I could be home, if things were to change at home, if I could contribute in any small way and plough this back."

Her talk at the conference was brief, too brief perhaps, for there can be misunderstandings between those who practice African and Western ideas of medicine: "We're not saying that either is better, just that there are differences."

But orthodox Western medicine is becoming interested in traditional African medicine because it brings in the cosmology, the world view, and what constitutes good or ill health.

"It has to do with body and mind — the balance between the social being as well as the physical being."

THERE is a mushrooming, mainly in the cities, of the traditional healers, for the people don't have easy access to Western medicines and techniques.

There is no doubt in the people's minds of the effectiveness of Western medical practices. But Western medicine was extended to African people without also extending clinical psychology and psychiatry.

"So when I talk of African people's perception of health needs, I'm not implying that they have entirely varying ideas, I am saying that there are differences in the emphasis on the harmony between body and mind.

"Being ill to the people is also being ill socially. If your mind is not in good order, you are ill and you need treatment along those lines.

"Those that can offer that type of treament are traditional practioners."

There are four categories of healers, the leading being the diviners.

"In literature they are wrongly called witchdoctors. These are the custodians of the world view, of the philosophy, if you like, of how the world operates. They were mainly women who went through tremendous training, with a lot of hardships. You don't really choose to be a diviner, there are indications that you are one. And it is a job that combines psychiatrist, priest and medical doctor.

"Today there is an increasing number of men who claim to be diviners — perhaps they are, it's a change and we need to study it."

Secondly, there is the inyanga — the medical practitioner who has not necessarily gone through spiritual training. Anyone, traditionally mainly men, can study to be an inyanga, it involves chiefly learning how to use the various medicinal substances.

Thirdly there is specialisation: "Certain families would have certain healing skills, in producing snake bite antidotes, or treating fractures, or preparing medical substances to ease child-birth. This healing does not involve any ritual, it would be purely scientific. Unlike the first two which deal with both physical and social illness."

Fourthly, there is faith healing, which also represents the world view and interprets an illness accordingly.

IS Professor Ngubane a healer?

"I tried to be one. When I did field work I asked an inyanga to train me. He was a bit amused and said: 'It'll take two years and at the end of that you'll have to pay me a beast, a cow. You will have to stay with me and when I go to collect medicine in the forest, you'll be digging and chopping. You'll visit the sick with me day and night.'

"If all this is said to you in the countryside by a man you realise how impossible it is for a woman to do it!

"So I went to the diviners and asked if I could be a diviner and they said: 'we don't decide to be diviners, our ancestral spirits decide to work through us. You will have to wait for signs from the spirits.'"

She is amused by her lack of luck, but says, "all that I have said now can be misinterpreted by people who say I am talking about the exotic nature of our society which the white people only want to listen to as something which marks the backwardness of our traditions."

It is this that her new book will address. There isn't time now — she is off to a meeting

A brisk visit from the world doctor and the patient recovers

The president of the World Medical Association files a glowing report on the state of our health care — and provokes a storm over relations between medicine and apartheid. SHAUN JOHNSON reports

SOUTH AFRICA has been given a clean bill of health after a doctor's inspection.

Medical services are excellent, racial and security "problems" which affect health care are being addressed sincerely and, where progress is stunted, it is because of "unethical and amoral" sanctions.

This is the view, not of Pretoria's director of health services, but of the president of the World Medical Association who paid a fact-finding visit to South Africa earlier this year.

Dr Lindsay Thompson's sanguine and conciliatory conclusions, published in the *South African Medical Journal*, seem set to cause a storm over the country's medical image abroad.

His portrayal of South African health care has drawn sharp condemnation from the National Medical and Dental Association.

Namda has undertaken to correct publicly what it sees as a "peculiarly one-sided attitude" and an apology for apartheid health services.

The organisation is considering making official representations to the WMA and will prepare a detailed response for publication in the SAMJ.

Thompson, an Australian, was in South Africa as a guest of the Medical Association of South Africa from February 21 to March 4 this year, and based his findings on the visit.

Masa is the largest medical association in South Africa, and its history has been plagued by controversy — most notably in the aftermath of the death in detention of Steve Biko.

While Thompson's report concedes that South Africa "continues to have political problems", it adds that the country "faces the unique situation that its medical problems are those of both the First and Third World. I am impressed regarding the overall awareness of the medical problems and that sincere efforts are being made to cope with these problems ...

"I am convinced that in both the educational and health sections great progress is being made, especially in regard to the black population."

Thompson praised the standards in South African teaching hospitals and primary health care facilities, as well as "the dedication and enthusiasm being shown by South African nurses and doctors of all races".

Regarding the medical care of prisoners and detainees, he said "while ongoing concern and vigilance is necessary ... great advances have been made". He commended Masa for their efforts and put on record his "appreciation for actions taken by the South African government" over detainees.

Namda's Dr Helen Schneider said this week that Thompson's pleasure over "improvements" in health care for prisoners and detainees — specifically the "panel system" whereby detainees are supposedly able to call in Masa-approved doctors for second opinions — misses the point. The issue for Namda is "detention without trial is in itself inimical to health".

Thompson was not challenging the system of detention, said Schneider, and seemed to be merely commenting on ways of improving it.

Namda's Dr Max Price also challenged Thompson's stress on ethnic factors and his reference to "First and Third World" problems. "If you separate everything into black and white," Price said, "you will obviously produce different circumstances, which can then be judged by different standards.

"In fact, the huge difference between black and white infant mortality rates, for example, is not because one group is backward but a result of unequal access to resources. This is the product of the political system."

Criticism of the government in Thompson's lengthy report is restricted to the fact that "by world standards, the Republic of South Africa is underspending on its health services", and to the "waste of resources" caused by the existence of 13 separate departments and directors of health.

Thompson says "there may be good political reasons for this but I feel the results could be disastrous from the health point of view".

He reserves much greater ire for those who support academic sanctions ("I found no support for sanctions ... among blacks or whites"), and for Namda, which he describes as a "ginger group within the profession with a centre-left political stance on most matters".

Thompson is at pains to draw a distinction between Masa and Namda. While criticising the latter for its activist-orientation, Thompson gives Masa his "highest commendation".

"It does not concern itself in party politics but does speak out and take a strong position on socio-political issues relating to health care," he says.

The Namda representatives rejected Thompson's separation of "socio-medical" and broader political issues.

"He defines health in the narrow and conservative sense," said Price, "merely as the presence or absence of disease. We see health as including emotional and social well-being — even purely physical well-being directly linked to access to power and resources."

Noting that Namda's "critics regard it as a frankly political body allied to the African National Congress which is stated to be largely under communist control", Thompson says he is "convinced that the organisation, through connections overseas, has spread inaccurate information aimed at the expulsion of Masa from the WMA".

Namda's Dr Fazel Randera said that the comments about Namda's position "bordered on the libellous", and "were strongly reminiscent of views expressed by the government".

Namda was not actively campaigning for Masa's expulsion from WMA, she said. "There are much more important things to do here. Our fundamental concern is with what is happening inside the country."

Randera said there were "recurrent attempts to undermine progressive organisations by claiming they are instruments of the Communist Party or the ANC — and this accusation has been levelled at Namda before. But there are plenty of reasons for forming a medical organisation critical of the government without needing outside instigation."

Price and Schneider also came out against Thompson's statement that Namda was "unable to produce concrete evidence" to support its "reservations regarding possible psychological torture of prisoners and detainees".

Emergency restrictions ruled out the publication of details of conditions of detention, they said: "Our work in the form of a detainees' service produces ample evidence — if it has not been made public recently, that is because the state has made it illegal."

SA unable to finance medical increases

PRETORIA. — President P W Botha said on Saturday that South Africa had reached the stage where the state can no longer finance the cost of supplying medical services at the rate at which such costs are increasing.

Mr Botha, speaking at the official opening of Meulmed Hospital here, said available resources would have to be used more effectively and the authorities would have to scale down contributions to health services.

He said much could be achieved if privatization could help keep hospital and health services within bounds and at least provide primary services for all. — Sapa

The Star Thursday August 18 1988 3S

Scientific papers withdrawn from congress in protest

By Toni Younghusband, Medical Reporter

At least five scientific papers, including one by a Zambian delegate, were withdrawn from a medical congress in Warmbaths yesterday because of a racial dispute.

The epidemiological congress, organised by the Department of National Health and Population Development, was held at the Overvaal resort which normally only admits white guests.

Special permission was obtained by the department for black delegates to attend the congress. But many of the 200 delegates were very unhappy at the choice of venue.

"It was felt that the least the department could do was to apologise for choosing such a venue. When they did not, a number of us left," said one delegate who asked not to be identified for fear of losing his State-held job.

Papers by delegates from the Universities of the Witwatersrand, Natal and Cape Town and the National Centre for Occupational Health were withdrawn from yesterday's conference agenda. No public explanation for the papers' withdrawal was given, but it was later learnt that these delegates had walked out of the conference in protest.

A Lusaka doctor also withdrew from the congress. He was to speak on Aids in sub-Saharan Africa.

Members of the Epidemiological Society of South Africa, an independent organisation, declared they would never again attend a congress at a racially-segregated venue. Next year's congress is to be organised by the society itself.

Dr H Kustner, the Department of Health's director of epidemiology, said: "When we arranged this congress we made sure everybody would be welcomed and that nobody would be affronted."

He said there was no reason for the venue to have been changed or for an apology.

"They knew about the venue before the congress, why didn't they say something then?" he asked.

Dissatisfaction grows in nursing

(85)

By VASANTHA ANGAMUTHU

WORSENING conditions in the nursing profession has seen members of the profession getting more and more militant.

Recent developments, like the increase in residence fees by over 100 percent, were contributing to the nurses' dissatisfaction, according to a spokesman for the Health Workers' Organisation.

"This has forced nurses to move away from their traditional roles of humility and servitude. They are now beginning to take up issues," he said.

The spokesman said the Baragwanath strike, the Shifa dispute and the Natal Settlers' Home work stoppage demonstrated the growing tendency towards militancy

The HWO spokesman described the rent hike from R56 to R108 for student nurses and R120 for trained staff as "unreasonable and shocking".

"Nurses who live far from their places of employment are in dire need of accommodation. And to expect them to pay these exhorbitant rents is shocking.

"Many nurses are opting out of the residences, but surely this is not a long-term solution."

Dr Charles Roper, director of hospitals services for the Natal Provincial Hospitals, confirmed that residence fees had been increased.

However, there were moves at top level to reduce the fees.

"Negotiations at top level on a national basis are taking place for a reduction in fees so that the increase to R177 in October is not implemented."

Star 30/8/88

Fragmentation causing 'wastage of resources'

Health service unity needed

By Toni Younghusband, Medical Reporter

The only way South Africa could successfully control the spread of disease was through the unification of its health services, Professor Solly Benatar, head of Cape Town University's medical department, said yesterday.

He told delegates at a medical congress in Sandton that "if we fragment our health services rather than unify them then we are not going to successfully combat disease, no matter what we do".

Infectious diseases were responsible for the second highest mortality rate in South Africa, Professor Benatar said.

Whatever medical milestones had been achieved in this country were being ignored by colleagues overseas.

"Whatever our achievements have been, they are being seen as of little importance in the face of our politics.

"The rest of the world has set us on a path of destruction and will not stop until there are equal rights for all in this country," he said.

Professor Benatar said what was needed was a great deal of co-operation between the peoples of South Africa.

"I would like to say that if South Africa is going to succeed in all areas we are going to have to unify rather than allow fragmentation to occur".

South Africa was divided into 14 independent geographical and political areas for the purposes of health-status monitoring and health-services provision, Professor Benatar said

Dr Carel Ijsselmuiden, of the department of community health at Wits University, said this was further complicated by the fact that the prevention of infectious diseases in so-called white South Africa was the responsibility of more than 800 local authorities and of the Department of National Health and Population Development.

"There is no binding mechanism for the centralised setting of standards, for the monitoring of infectious diseases or for the evaluation of the activities aimed at their prevention.

"This fragmentation not only makes for operative ineffeciency and lack of co-ordination, it also promotes an enormous wastage of resources which could have been used to combat infectious diseases," Dr Ijsselmuiden said.

Prevention better than cure

The redistribution of South Africa's health budget would dramatically improve health conditions, delegates at a medical congress heard yesterday.

Dr Derek Yach, of the Medical Research Council at Tygerberg Hospital, said the shift from curative spending to preventive spending would make a dramatic impact on health care.

Good living conditions vital to health

Medical Reporter

Advanced medicines would do little to improve health conditions in South Africa if the current socio-economic climate remained unchanged, Dr Carel Ijsselmuiden, of the Department of Community Health at Wits University said yesterday.

He said that this century improvements in socio-economic conditions had been more important in reducing infectious diseases than medical care.

He said poverty and a lack of adequate resources, such as housing, education and sanitation, all contributed to an increased incidence of disease.

"In South Africa a lack of adequate housing and overcrowding have shown to be related to an increased incidence of tuberculosis and have recently again been associated with an increased incidence of measles.

"Poor education, inadequate water supply, malnutrition and civil unrest all work against the control of infectious diseases."

Dr Derek Yach, of the Medical Research Council in Cape Town, said that within racial categories, diarrhoeal incidence was strongly related to social and economic factors.

Masa fees up 10% in January

Bladay 7/9/88

THE Medical Association of SA's (Masa's) recommended tariffs for doctors will rise by 10% from January 1989, and it is expected that general practitioners will get an additional, substantial increase.

A Masa spokesman said the GP consultation fee was now being reviewed and a decision was expected later this month.

The Representative Association of Medical Aid Schemes' (Rams') scale of benefits was also under review and a final decision would be taken once Masa's amended guide to fees had been studied, Rams executive director Rob Speedie said.

GERALD REILLY

The Masa spokesman said Rams' scale-of-benefit fees were currently 50% lower than Masa's recommended fees.

Masa recommended a GP tariff of R27 a consultation, but most GPs charged R15.

Doctors, he said, seldom charged the Masa-recommended tariffs.

Deaths due to lack of health sevices

Own Correspondent

JOHANNESBURG. — A lack of health care in parts of SA is leading to a huge proportional increase in black infant deaths, said Dr H G V Kustner of the Department of National Health and Population Development yesterday.

Addressing the conference on population development in Southern Africa, Dr Kustner said SA health services faced a dilemma.

The dilemma amounted to the "very noticeable disparity between the undisputed excellence of the hospital-centred health care offered in this country versus the basic, yet essential community-oriented primary health care services".

A breakdown of the infant mortality rate over the past five years emphasized this inadequacy. Three white babies in 1 000 died over this period, while the statistics for black babies were between 94 and 124 per 1 000. Coloured babies had an infant mortality rate of 52 per 1 000 and Asians 18 per 1 000.

Infant mortality rates assumed special importance, he said, because they were commonly used as indicators of health and the effectiveness of health services the world over.

In the black communities, childhood mortality was attributable to a number of infectious diseases, especially gastro-enteritis, but also infections of the respiratory system. Immunization against certain diseases would also alleviate the high mortality rate in these communities, said Dr Kustner.

Hope for future generations of disadvantaged children, who have a dramatically higher chance of dying in their first year of life than their white counterparts, lay in improved community midwifery and the strengthening of basic primary health care, Dr Kustner said.

'Health is our right'

Deal with 'unacceptable' conditions

By KERRY CULLINAN

"HEALTH is our right and the responsibility of the State," said the Soweto Community Health Committee this week in a letter to the Minister of Health, Dr WA van Niekerk.

The committee futher demanded that Van Niekerk deal with "unacceptable" health conditions in the township.

In the letter, written after Van Niekerk had visited Soweto and had remarked about "improved conditions", the committee lists as unacceptable:

- The "dangerously polluted" air caused by "power cuts and teargas".
- An increase in hospital tariffs.
- The conditions at Baragwanath Hospital.
- The victimisation of health workers.
- The authorities' dismissal of municipal workers, which has led to unhealthy conditions, such as no rubbish and sewage removal and undug graves.

"We are tired of hearing that the government has no money for services while we see our streets lined with expensive military vehicles," added the letter.

The committee is made up of representatives from youth, student, teacher, women's and civic organisations.

According to a HWA member, a number of committee members have been victimised, the latest being the detention on September 10 of committee member Pammy Majodina.

Police do not comment on emergency detainees.

AA warns motorists of wet weather driving hazards

CP Reporter

ACCORDING to the Automobile Association, the onset of the rainy season will

cars are fitted with anti-skid brake systems which increase their brake effeciency under heavy braking on smooth wet roads or

R300 000 for SA medical research

Star 28/10/86 (85)

By Joe Openshaw

Spending on medical research in South Africa compared poorly with developed countries, Professor A J Brink, president of the the South African Medical Research Council (MRC), said in Johannesburg yesterday.

Speaking at a luncheon at which Wellcome South Africa announced they would be contributing R300 000 over the next five years to medical research, Professor Brink said South Africa spendt one percent of its gross national domestic expenditure on reasearch and development compared with Israel's three percent and Japan's 2,6 percent.

SPECIAL NEEDS

"Research is needed because we have a developing and developed peoples with special and particular health needs," he said.

"The third world represents the impoverished and less privileged with attendant socio-economic diseases — among them malnutritition.

"The first world is prone to a destructive lifestyle associated with smoking, drinking and environmental pollution."

He said that rapid urbanisation had led to other health needs and there had been a spread of diseases from bordering states by refugees, migrant labour and immigrants.

These included different strains of malaria and Aids.

He said he welcomed the company's gesture because it would stimulate medical research, encourage researchers and make the public aware of the important of the work.

Mr Colin Loubser, chief executive of the company, said it would be an annual award — the Wellcome Medal for Medical Research — worth R40 000 initially.

"This amount will escalate by 15 percent each year.

"It will go to the a reseacher whose work in the opinion of a panel of judges is of great importance to this country," said Mr Loubser.

A panel of judges chaired by Professor Brink will be Professor T H Bothwell, Wits University; Professor A du P Heyns, University of Orange Free State; Professor M C Berman, University of Cape Town; Professor J J F Taljaard, University of Stellenbosch; Professor G S Fehrsen, Medunsa; Professor S Killichurum, University of Natal; and Professor W Prozesky, University of Pretoria.

In the company's history there are three Nobel prize-winners for medicine and physiology — Sir Henry Dale in 1936, Dr John Vane in 1982, and Dr George Hitchings and Dr Trudy Elion, who jointly received the prize for medicine and physiology with Sir James Black this year.

(85) WMAIL Oct 28 - Nov 3 1988.

A socialist broadside in the battle for the nation's health

A new book makes a powerful case against the much-touted privatisation of health care in South Africa.
JOHN PERLMAN *reports.*

"WE'VE met people from many places — Nicaragua, Zimbabwe — who said they woke up after independence and were told 'now build a popular health service'.

"Political change will not bring about automatic change in the health system."

The words are those of Cedric de Beer, of Wits University's Centre for the Study of Health Policy, which has just put out a book called *A National Health Service for South Africa, Part One*

The title may be uninspiring and the print run tiny (750 copies), but the book fires the opening salvo in a theoretical battle with far-reaching consequences for South Africa's future.

It states the case for a socialist solution to the country's massive health care problems, and is prompted as much by ideas about post-apartheid South Africa as by the failings of the current health service.

De Beer stresses that the document is more than an "an alternative view for alternative people".

"We see current policymakers and people who influence them as part of our audience," he says. "Business, government and the health departments could benefit from reading what we write."

"The subject is of importance to the public, to anybody who has to go and see his doctor," adds Joan Mavrandonis, another of the authors.

"And in medical circles, there has been since the early 1980s a resurgence of debate around the issue. The push towards privatisation of health services has brought it more sharply into focus."

Part one of the book, subtitled "The Case for Change", paints a dismal picture of health and the existing health system in South Africa.

The authors make their assessment in part by using World Health Organisation (WHO) indicators of a population's health, such as nutritional status, infant mortality rates and life expectancy.

According to a 1984 estimate, 33 percent of black children below the age of 14 are underweight and stunted, compared to five percent of white children of a similar age.

Statistics for infant mortality rates in 1981-5, (which exclude the "independent homelands") show a figure of 94-124 per 1 000 live births for Africans, nearly 52 for "coloureds", 18 for Indians and 12 for whites.

The life expectancy of African men is 50-55 years, compared with nearly

The authors assess the ability of the health services to deal with current problems, using criteria for primary health care defined at the 1978 Alma-Ata Conference convened by the World Health Organisation and United Nations Children Emergency Fund.

These criteria include:

- Universal access to essential health care of adequate quality.
- Priority for those most in need of care.
- A primary health care system backed by integrated, functional and mutually supportive referral systems.
- Full community participation in the planning and implementation of health care.

In these terms, South Africa is a poor performer. Expenditure on preventable diseases, while difficult to calculate, was described in 1986 as deficient and declining in relative terms by the government-appointed Browne Commission, which looked into the health services.

Most recent figures show that only 39 percent of South Africans are fully immunised against measles, 45 percent against polio and 63 percent against tuberculosis.

Some idea of access to health services is given by doctor/population ratio — which is 1:14 000 in Lebowa and kwaZulu and 1:32 000 in kaNgwane — and by the number of clinics per head of population, which is 27 150 in kwaZulu, 17 487 in Qwa Qwa and 11 431 in kaNgwane.

These statistics, the authors say, do not take into account the availability of drugs and equipment, referrals for more sophisticated treatment and the distance and time taken to reach clinics.

A survey had shown that at Elim Hospital in the Northern Transvaal, three out of every seven fridges were out of order, thus breaking the "cold chain" for 90 percent of vaccine stored there. In Northern kwaZulu, 48 percent of clinic refrigerators were out of order.

And at another rural hospital, meant to provide out-patient service to 50 villages, over 70 percent of the patients were from the eight villages closest to the hospital.

If the state of the nation's health is alarming, the systems for dealing with it are equally so. The authors identify three phases in the fragmentation of our health services.

By 1920 a "tripartite system" had been set up, with the health services divided between local, provincial and national government. In the 1950s and 1960s, homeland health services were set up. And most recently, "tricameral health care", parts of it "own affairs" parts of it "general", were established.

Picking up the tab for this have been 14 government departments of health, four provincial bodies and about 800 local authorities.

"There is an excessive fragmentation of control over the health services and a lack of central policy direction. This has led to a misallocation of resources and to wasteful duplication of resources." These are not the words of the authors, but of the Browne Commission.

Privatisation of health care, say the authors, is already official state policy and is promoted by private sector think-tanks and by some sections of the medical profession. About half of South Africa's doctors already work in the private sector.

There are two main arguments for privatisation, the authors say. The first says it will draw more money into the health sector, resulting in better health care for all.

This ignores tax concessions to medical aid contributions (17 percent of public sector health expenditure in 1982) and the subsidisation of medical education.

It also assumes that if the state saves money by making those who can afford it pay, then it will use the money saved to give better care to the poor. Will this happen, the authors ask, if most South Africans with political influence use private doctors?

The second argument says the private sector will provide care more cheaply. The authors, however, stress that health is not an area where pure market forces apply.

"Faced with situations of great anxiety and technical complexity, consumers are unlikely to shop around, looking for bargains," they say.

The arguments against privatisation concludes "the case for change". Part two of the book, to be published later, will examine what a national health service for South Africa might look like.

Threat of medical isolation 'now lifted'

PRETORIA — Unanimous acceptance by the World Medical Association (WMA) of a statement rejecting academic sanctions has removed the threat of academic isolation for South Africa's medical profession, says chairman of the Medical Association of South Africa (Masa) Dr Bernard Mandell.

The South African-initiated statement said the WMA was opposed to restrictions and called on all national medical associations to resist the imposition of academic sanctions and boycotts and to adhere to the WMA's Declaration on Human Rights and Individual Freedom of Medical Practitioners.

The statement said restrictions which denied physicians opportunities to exchange information were a protest against the social and political policies of governments.

Such restrictions conflicted with the WMA's objective of achieving the highest international standards of medicine.

Sanctions also discriminated between physicians and patients on grounds of the political decisions taken by Government.

Dr Mandell said academic sanctions and boycotts were a serious threat to medicine as interaction with international experts was important to the maintenance of South Africa's high medical standards.

He said Masa was prepared to participate in a medical education congress in Johannesburg later this year on condition the National Medical and Dental Association (Namda) repudiated calls for the academic isolation of South African doctors.

"We feel we have an advantage over Namda as long as they propagate academic sanctions, especially in light of the internationally accepted statement," said Dr Mandell.

Namda's proposal of two-tiered medical education so as to provide more doctors was unacceptable to Masa because it would lower medical standards, he said.

Calls for academic sanctions were to some extent "immoral and unethical", said Dr Mandell. It was important for people to know about the threat and the WMA position.

DEBORAH SMITH

d job.

the faces of South Africans who

Star 22/11/88 (85)

Medical aid schemes' limit 70 pc

Seeing the doctor set to cost more

Patients may have to pay an additional 30 percent on their medical bills if an agreement between medical representative associations is accepted by the Minister of Health.

The Medical Association of South Africa (Masa), which represents the country's doctors, and the Representative Association of Medical Schemes (Rams), have agreed in principle that in future medical schemes will no longer be obliged to pay 100 percent of the scale of benefits for doctors' consultations.

However, minimum guaranteed benefits will not be less than 70 percent.

This means that the patient will have to cough up the difference between the amount charged by the doctor and the benefits paid by the medical scheme.

Individual medical schemes wishing to pay the 100 percent will be free to do so.

By Toni Younghusband
Medical Reporter

According to a joint statement issued by Masa and Rams yesterday, the purpose of the agreement is to encourage "responsible use of consulting services and to curtail spiralling costs".

The associations hope to discourage patients from utilising doctors' services unnecessarily.

Awareness of costs

"The introduction of this disincentive to patients will make them more aware of costs and of the standard of service they are paying for," the statement said.

Mr Rob Speedie, executive director of Rams, said medical schemes could not continue to burden both employers and employees with ongoing substantial increases in subscription rates.

"It is vital that we introduce disincentives in order to contain cost increases," Mr Speedie said.

A Masa spokesman said it was not yet possible to say exactly what amounts were involved as fee increases were expected next year and the scale of benefits was to go up by 10 percent.

"Nothing is final yet. We will meet again in January to finalise details of the agreement and joint representations will then be made to the Minister of Health for the appropriate changes to be made to the regulations issued under the Medical Schemes Act.

"If the Minister gives the green light it will take some time before the new system goes into operation," the joint statement said.

And if the Minister decides the new system necessitates changing the entire Medical Schemes Act, it could take more than a year.

CITY NATIONAL

Medical costs at crisis level

The Argus Correspondent

JOHANNESBURG. — South Africa was in a "serious crisis" concerning medical care and the whole system had to be investigated urgently, said Mrs Joy Hurwitz, the past president of the Housewives' League, today.

Mrs Hurwitz, who is conducting an intensive investigation for the league into medical costs, was responding to the disclosure in the Star, sister newspaper of The Argus, yesterday about the state tender system of purchasing medicine. By purchasing on tender, the state was buying its medicine as much as 80 times cheaper than the private patient.

Mrs Hurwitz said it was "absolutely alarming" to see by how much the price of medicine had gone up in the past year.

"The cost to the private patient is astronomical. It cannot go on. The more the price of medicine goes up, the higher the medical aid fees — until eventually you won't have anyone able to afford medical aid. They'll all become state patients and then where will the state be? It says it has no money to pay for the patients it has," said Mrs Hurwitz.

She also slammed the general sales tax and import duty slapped on medicines.

Import duty

"Why should we have 12 percent GST on medicine or, for that matter, why is there import duty? Medicines are not luxury items, you cannot avoid being ill," Mrs Hurwitz said.

She said while the government had promised to "look into" the medical situation in South Africa, little had been done.

Mrs Hurwitz will meet the Minister of Health, Dr Willie van Niekerk, on November 23 to discuss medical costs.

Dr van Niekerk this week rejected accusations by the Pharmaceutical Society of South Africa that the government was responsible for the high price of medicine.

He said the society wanted "protected free enterprise".

Mr Jack Bloom, chairman of the Southern Transvaal branch of the society, said Dr van Niekerk had failed to address the real issues at stake.

"The argument concerns the tender system. It is the tender system which pushes up the price of medicine. Dr van Niekerk has not answered anything at all," Mr Bloom said.

"Totally crazy"

He pointed out that pharmacists were already "protected" and what they were looking for was not protection for themselves but for the paying consumer.

"We are the interface with the public and they get terribly rattled when they have to pay high prices for their medicines. We cannot blame them. It is a totally crazy situation," Mr Bloom said.

He and other society members have called for a concerted consumer protest. A press advertisement had received widespread reaction, said Mr Bloom, both from consumers and the medical profession.

"The phone started ringing as soon as the newspaper appeared on the streets. Members of the public felt it was time something was done," he said.

The manufacturers of generic medicines have pointed out that the substitution of generics for brand name products would substantially decrease the price of medicines.

However, here pharmacists were to blame, one manufacturer said. Pharmacists were reluctant to recommend generics because lower prices meant lower profits for the chemist.

B/day 16/11/88

NATIONAL PARTY CONGRESS

Govt not to blame for high medicine prices — Minister

PRETORIA — The public should not point fingers at government for the high price of medicines, because the pharmaceutical trade controlled the "whole chain" and put 50% mark-ups on wholesale prices, National Health Minister Willie van Niekerk said yesterday.

He told the NP Transvaal congress that figures for last year showed the pharmacy trade had paid R650m for medicines, while the consumer had in the end paid R1,31bn, or R1,17bn without GST.

Government was committed to the lowest prices for medicines to the public, but the pharmaceutical trade controlled the entire industry, from the start of the price structure through to consumers.

People pointed fingers at the state tender system for drugs, but suppliers admitted "frankly" they made profits on sales to the state.

Van Niekerk said instead of pointing fingers at the state tender system, the pharmaceutical industry should "get its house in order".

The message from the public was clear, that it could not pay the high prices for medicines, and "the chemists must answer the public".

Lower

□ GERALD REILLY reports that the Pharmaceutical Manufacturing Association of SA's John Toerien said retail pharmacists should abandon the mark-up system on medicines and drugs and open the way to greater competition.

He was responding to claims that manufacturers sold to government at prices 40 times lower than they charged wholesalers.

On the claim that what they lost in the fiercely competitive tender battle for government supplies, manufacturers made up by loading prices to wholesalers, Toerien said he did not believe there was a single manufacturer who sold below cost or who exploited wholesalers.

Government bought vast quantities of medicines and drugs and was in a powerful bargaining position with manufacturers.

Toerien said: "To kick up dust about the government tender system is going at the symptoms and ignoring the disease.

"What is needed is a totally new structure solidly based on the free enterprise system from the manufacturer right through to the retailer."

Last year, medicine and drug prices rose by an average of 20%.

Initially this year an average price rise of 15% was expected. However the estimate was complicated by the introduction of the import surcharge.

The system provided for a wholesalers mark-up of 17,5%. The retailers mark-up was in excess of 50%.

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Talks on abortion

THE National Medical and Dental Association is to hold a one-day seminar at Funda Centre in Soweto on Sunday at 1pm to discuss "Abortion and the Law."

A spokesman said various experts in this field have been lined up to address the seminar. They include Professor E T Mokgokong of the Medical University of Southern Africa, Dr J M Mbere, a well-known Soweto gynaecologist, and Mr Dikgang Moseneke, a well-known Pretoria advocate.

The spokesman said they had arranged the seminar because they felt women were exploited and issues concerning them had not been addressed by progressive health organisations.

Members of the public are welcome to come and express their views. Those attending will be expected to make a R5 donation that will go towards refreshments.

Blood shortage in SA 'desperate'

20/12/85 Star (85)

Medical Reporter

South Africa is again faced with a critical shortage of blood.

A South African Blood Transfusion Service spokesman said yesterday there was a desperate shortage among all blood groups.

"If stocks cannot be built up, we will not have blood and blood products to meet the daily demands or to supply blood in an emergency or disaster situation."

The service has made an urgent appeal to the public to donate blood.

The fight for rights for the disabled

KATHY JAGOE . . . The co-ordinator of UCT's disability unit in her office yesterday.
Picture: RICHARD BELL

Medical Reporter

KATHY JAGOE is disabled but she is not handicapped — except by obstacles placed in her way by society.

Ms Jagoe, a quadraplegic and co-ordinator of the University of Cape Town's year-old Disability Unit, said in an interview yesterday that disability was a political and social issue.

"One has to be very careful to distinguish between the terms 'disability' and 'handicap'. Disability is intrinsic to the individual, but a handicap is anything in the environment — like attitudes, health care, employment issues — that prevents the disabled person from leading an integrated life. A handicap is changeable," she said.

Ms Jagoe, who was 16 when she was injured in a diving accident in East London in 1970, said her university training had been in fine arts and education.

"But eventually I told myself anyone could be an art teacher, and decided to concentrate my research on the area of disability.

"I was lucky in that I am white, that I have a supportive, educated and financially well-off family and that I was able to stay at my normal school and go to university. But a lot of people are not that lucky and I decided to work for the rights of disabled people," she said.

Ms Jagoe lectured in disability studies at the University of the Witwatersrand for eight years and started the country's first disabled students' programme there before deciding to make a move to Cape Town.

Students' problems

"I wanted to spread my work as widely as possible and so I agreed with the university to start a disability unit, which is presently funded totally from outside sources."

The work of the unit concentrates on three areas — working with disabled students to try to solve their practical problems in studying; working with planners, architects and builders on improving access to campus; and teaching disability studies to students in fields such as sociology, social work, medicine, engineering and architecture.

"This year I've been concentrating on making contacts and educating at an informal level, and on studying existing access problems at the university. I have found a great willingness to make things accessible to students, but it is very often done incorrectly and hampered by lack of finances," she said, adding that UCT was no different in this regard from the rest of society.

Examples of incorrect design found at the university were ramps without grab-rails and crash barriers, or toilets for wheelchair users which were situated in male and female cloakrooms.

"This means that a disabled person is limited to being helped by peers of the same sex — toilets for wheelchair users should be separate from male or female cloakrooms," she said.

But Ms Jagoe does not want to be writing critical reports to the university.

"I just want to see things done correctly. What I'm trying to say to the university administration is that they should not feel sorry for disabled people — they should just concentrate on providing facilities that give disabled students an equal chance with other students."

HEALTH & DISEASE — GENERAL

1989

Medics in a tizz over indemnity cover

ST Times 15/11/89

85

PRICEFORBES Volkskas subsidiary Medical Liability Services of SA has shaken the medical and dental professions by introducing an alternative form of professional indemnity protection.

Competition is considered healthy, but this new product is causing considerable tension. The Medical Association of South Africa is pragmatic in its acceptance of the scheme, but the Dental Association objects to it. The executive director of the Dental Association sent a four-page letter to members urging them to reject the cover.

Reasons

David Campbell, director of Medical Liability Services, explains some of the reasons for the resistance.

"Up to now the cover, also known as malpractice protection, has been available only through the various medical and the dental associations which arrange the insurance with two friendly societies in the United Kingdom. These two societies have had a monopoly for 102 years.

"The medical and dental associations receive a brokerage or handling fee which contributes to their running expenses. There is no limit of liability to these schemes — providing the funds are available.

However, no insurance policy documents are supplied and claims are settled on a discretionary basis.

Business Times Reporter

The arrangement has proved satisfactory, but two Johannesburg doctors investigated why premiums were increasing each year.

Fear

They questioned whether the premiums reflected South African claims or whether they were based on the experience of European and other First World countries. Last year in Britain a court awarded a claim exceeding £1-million.The investigating doctors bewlieve SA's medical profession is supplementing a global claims experience.

One says: "There is a growing fear among doctors that the friendly societies, which are not insurance companies, could run out of funds if claims and awards increased at their present rate."

In addition, the doctors fear buying foreign cover with weak rands. There is also the worry that claims funds might be blocked by sanctions should there be a change in attitudes and policies in Britain.

The two doctors approached PFV with a view to providing the SA medical profession with cover at realistic rates and with a policy document that is legally binding.

The cover is underwritten by an SA insurance company and reinsurance is provided by companies with funds in this country.

Without access to all SA claims data, including those settled out of court, the company has decided to peg premiums at the same rate as those charged by the friendly societies last year.

Computer

With the aid of the PFV computer facility, premiums may be paid annually or monthly. The liability limit is retricted to R5-million a claim, which is more than double any kown malpractice claim in SA. Other benefits are similar to those offered by the friendly societies — legal costs and advice.

A similar competitive scheme has been running successfully in Australia for a year and a firm of Lloyd's brokers has been asked to obtain cover for a professional indemnity product for the medical profession in the UK.

Algae killer

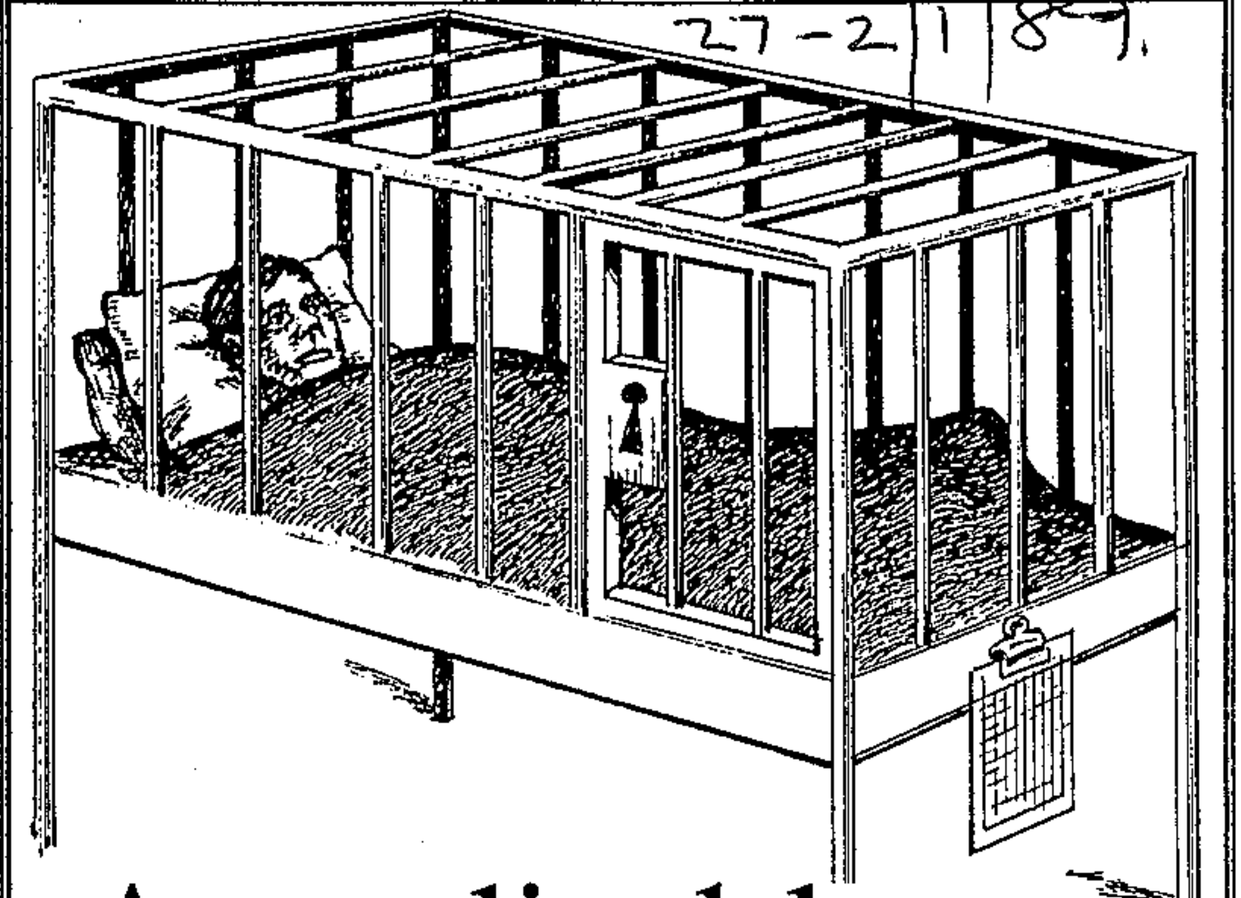
A SWIMMING-POOL product, which is claimed to be a world first in the control of algae, has been developed in SA.

Called Spalsh, the purifier reduces the need for chlorine and does not stain pool walls. It is produced by Universal Coatings.

Splash, which has been tested for two years, has attracted attention in America and Australia.

... makes extensively ... manager

(85) W. Mail 27-2-1989.



A medical lesson for us from Chile

A law professor says South African doctors should learn from their Chilean counterparts who, having initially supported the military regime, soon became powerful opponents of the physical abuse of detainees.

By CARMEL RICKARD

THE Medical Association of South Africa (Masa) has been likened to the Chilean Medical Association (CMA) which before 1981 "supported the Pinochet government's violation of human rights".

The accusation appeared in an article on the responsibility of doctors during the State of Emergency and was written by David McQuoid-Mason, professor of law at Natal University, Durban.

Writing in the latest edition of *Acta Juridica*, law journal of the University of Cape Town, he criticised Masa for not having taken a stand on the ethics of treating detainees. Its publication came shortly before a Transvaal court was to scrutinise the conduct of doctors responsible for the care of a student leader who died in detention.

However, McQuoid-Mason argued, the CMA had subsequently become "a powerful opponent of such government policies", and he suggested that a correct understanding of the responsibility of doctors could lead Masa to make a similar change.

McQuoid-Mason said Masa should co-operate with medical human rights organisations and issue clear instructions to its members concerning the treatment of detainees.

While Masa and the South African Medical and Dental Council did not have such guidelines, the CMA had drawn up instructions to its members and published them in the media, so that the public would be aware of what was expected of doctors.

Under the CMA guidelines, medical practitioners were told not to attend patients if third parties in any way obstructed the professional relationship between the physician and patient. If, despite these guidelines, doctors were forced to attend to a patient through a medical emergency or through threat, they were required to inform the CMA within five days.

McQuoid-Mason said there were a number of ethical problems for doctors treating prisoners and detainees, particularly relating to conditions of treatment and confidentiality.

Dealing with the right of a detained patient to treatment, he said medical treatment was "not a privilege to be granted at the behest of the police or prison authorities", and any attempt to prevent, or omit to provide medical treatment, would be regarded by the court as unlawful.

There was a legal duty on "the person who has control over the prisoner or detainee to provide the treatment". If, as a result of the failure to provide treatment a detainee dies, "the prison or detaining authorities" will be held legally responsible.

McQuoid-Mason said many detainees have complained they were denied proper medical attention, "either as a result of police obstruction or through indifference by the medical officers and district surgeons".

He quoted a study by the National Medical and Dental Association which indicated that of 131 former detainees interviewed, almost 25 percent said they had not seen a district surgeon during their detention. Of the 27 percent who said they had asked to see a doctor, nearly 66 percent alleged their requests were refused.

In terms of the law, very few detainees had access to private doctors and in most cases their only contact with the medical profession was through state employed medical officers and district surgeons.

"This means state employed doctors have a very important role to play in the protection of the health and bodily integrity of detainees. Unfortunately they have not always acted as responsibly as they should in terms of the ethics of the medical profession."

He said he believed medical practitioners should refuse to treat prisoners and detainees where they were not allowed to carry out proper treatment, where the person was being kept in cruel, inhuman or degrading circumstances and where the patient could not be examined in private.

McQuoid-Mason contrasted the role played by Masa in maintaining this ethical standard, with that of its Chilean counterpart.

"(The CMA) has moved from almost 'active complicity in the Pinochet government's violation of human rights' to becoming a powerful opponent of such government policies.

"The CMA has linked up with legal and human rights organisations and encourages its members to participate in preventing abuse of detainees and to provide medical affidavits to support complaints of torture.

"It also holds disciplinary hearings against physicians charged with complicity in torture and has financed advertisements in the press setting out guidelines that strictly prohibit physicians from collaborating in torture."

He said the CMA had admitted its own history in this regard, and in official CMA minutes had noted that it was "painful" to recognise that it had been a "mere spectator to the institutionalised violence taking place around it".

The official minutes continued, "The association failed to protest this violence, inquire about its causes and denounce those responsible. Moreover, the association disclaimed reports that physicians were present during the torture or ill-treatment of detainees held in centres run by the security forces."

McQuoid-Mason said Masa had similarly been accused of "continuing equivocation" on the question of detainees and had attacked studies by the National Medical and Dental Association on the effects of detention.

Masa was "still equivocal" on crucial issues: it had not yet "officially denounced the policy of apartheid, or detention without trial, or the detention of children, even though it has acknowledged that some detainees have been seriously abused".

He said Masa should, like the CMA, "define clearly for medical officers and district surgeons the nature of their medical ethical responsibilities, and the professional consequences of misconduct".

He urged that Masa co-operate with Namda and that the medical profession as a whole should be prepared to condemn unequivocally any doctor who failed to expose police brutality or torture.

On the other hand when practitioners, like Dr Wendy Orr, were courageous enough to expose police ill-treatment of detainees, they should be supported by other members of the profession.

McQuoid-Mason said Masa should demonstrate to the South African government "that it is fully prepared to support members of the medical profession who oppose the torture and ill-treatment of detainees".

Masa banquet dispute as CP tightens screws

Star 28/1/89

THE Krugersdorp Council will not allow black people at functions in any of the town's municipal halls as the majority of the councillors are opposed to the idea of "other races" using these facilities.

This message was put across firmly at a press conference yesterday by Mr Sakkie Nel, chairman of the management committee. He assured residents of Krugersdorp that "darkness will not fall over the town if the halls are closed for blacks" and said "the fights in the dorp will not die as a result of the council's decision".

The West Rand branch of the Medical Association of South Africa (Masa) booked the Centenary Hall in October last year for its annual function, to be held in February. On the application form, next to the space for the number of whites attending, the association indicated there would be about 400. It left blank the space indicating the number of other races attending, as it was unsure exactly how many would be attending the function.

85

GIEN ELSAS

300

In January, the association wrote to the council and stated, as an addendum to its application, that not more than 10 percent of the function's patrons would be of "other races".

At the council's monthly meeting this item was debated at length. The council went into committee and recommended that the hall be rented to Masa as per its application of October. In other words, about 400 whites would be allowed to attend the function.

When asked what would happen if black doctors and their partners arrived at the function, Mr Nel said the council's policy would then be enforced.

Dr Hannes Grobbelaar, the Association's West Rand president, said after the meeting: "The association will still hold the function. We are holding a meeting early next week and it is probable that we will not make use of any hall which is under the jurisdiction of the council."

Mr J J L Nieuwoudt, Krugersdorp's town clerk, said yesterday the council had accepted an application made by the West Rand branch of Masa to hold its banquet.

He said the council decided at a meeting on Wednesday to grant permission under the terms in which the application was made. According to Mr Nieuwoudt, the application requests the use of the hall for 400 white people.

However, Dr Douglas Gurnell, a banquet organiser, has denied that the application was made for white doctors only.

"On the application form, the council asks for the number of people of each race who will be attending the function.

"When our secretary took the application form in to them in October, she explained that we did not know how many of each race would be coming as we still had not sold tickets for the banquet.

"The person she handed the form to said this was not a problem and the number could be filled in at a later stage," said Dr Gurnell.

A letter was, however, sent to the council informing them that "non-white" members would be attending.

The Conservative Party-controlled town council's management committee then recommended that black doctors be banned.

Dr Gurnell said Masa had already paid the deposit on the hall.

"If our black members are banned we will most certainly not carry on with the banquet," Dr Gurnell said.

He said Masa was a non-racial organisation and could not tolerate members being banned for reasons of colour.

'Villain' enters Boksburg farce

Weekend Argus Correspondent

THE SHOW: Boksburg farce, Part 13.

THE SETTING: Boksburg's empty parks, Boksburg's empty shops, the Boksburg council chamber.

THE DIRECTOR: Andries Treurnicht, leader of the Conservative Party.

THE STARS: Gideon Fourie, leader of the Conservative Party in Boksburg and the entire CP caucus.

THE SUPPORTING CAST: Blacks, coloureds, Indians and all communists, ANC supporters, radicals, liberals and kaffir-boeties.

SPECIAL GUEST APPEARANCE: Mrs Dawn Jacob, head of the Boksburg Publicity Association.

THE Boksburg farce has undergone considerable adaptation since it first captured the imagination of the South African public last November.

But drama-lovers will not be disappointed by the latest offering from this authentic, indigenous, all-white cast.

Admittedly, the lustre seems to have gone out of the first half of the show. The supporting cast has disappeared as the farce moves from Act One (neat, orderly and empty parks) to Act Two (neat, orderly and empty shops).

But activity picks up in Act Three, set in the hallowed council chambers.

Riveting performance

In a riveting, nine-hour performance, the city fathers deliberate on how to oust the "enemy" Boksburg Publicity Association from the town and decide to give it a month's notice to vacate its offices in the civic centre.

In a virtuoso display of perception, chief supporting showman and former traffic policeman, CP councillor T J Ferreira, remarks that the association's presence at the centre is the "same as allowing the ANC to sit in government offices in Pretoria".

Special guest star, independent councillor and chairman of the Boksburg Publicity Association Mrs Dawn Jacob, comes in for a tongue-lashing and is accused of using the association as a way of "getting back at the CP".

Comic irony

Showing a fine appreciation of the use of comic irony, Boksburg CP leader Gideon Fourie accuses the publicity association of giving Boksburg a bad name. (Followers of the farce may recall Mr Fourie's November debut when, in justifying the CP's decision to fence off its parks to blacks, coloureds and Indians, he declared: "We are Christians. We believe in giving to others what we have for ourselves.")

During Act Three all is revealed about the publicity association's dastardly campaign to ruin the town.

Its first mistake is to call the CP's race policies "repugnant".

The all-Christian conservative cast is further enraged when the association cancels its annual Carols by Candlelight service on the flimsiest of grounds — that blacks can no longer participate in the service at the Boksburg Lake.

Final straw

The final straw is when the publicity association shelves plans for public amphitheatre at the Boksburg Lake.

Mrs Jacob is dazed as the curtain falls on the council meeting at 1.30 am. Chairman of the publicity association for five years, Mrs Jacob seems puzzled by her new role as villain in the Boksburg farce.

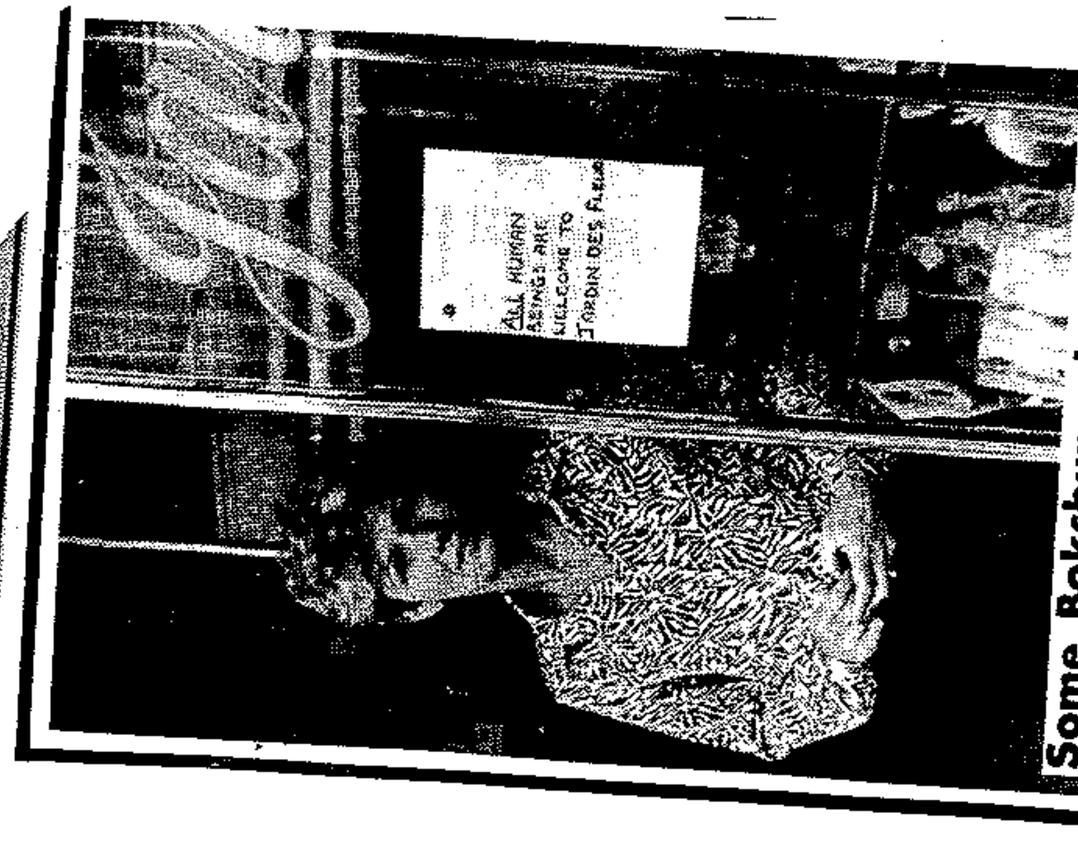
But the CP players seem satisfied with their performance.

The councillors may have managed to deal with only two-thirds of the normal council business at their meeting, but they have made great strides in their campaign to save Boksburg.

Roars of applause from stage right.

Reviewed by: COLLEEN RYAN.

POLITICS



Some Boksburg shopkeepers reacted to the town's policies by ensuring that all races were welcome.

Dr Paul Davis talks to the Press outside Johannesburg Magistrate's Court yesterday after a subpoena compelling him to give details of 40 detainees was dismissed.

Picture: ROBERT BOTHA

battle to find ne — Actstop

PETER DELMAR

crowded it would be almost impossible to find Dayal a house there.

The spokesman said Dayal had received no official notification of Meyer's offer to help.

Homestead Park Residents' and Ratepayers' Association chairman Allan McCabe said any government attempt to settle the Dayal family in white Mayfair would set a precedent which would signal that the authorities had no intention of halting the greying of the area.

CP Johannesburg chairman Fred Rundle said white residents would strenuously resist an attempt to move Dayal into white Mayfair.

Order on doctor facing jail quashed

BRONWYN ADAMS

PHYSICIAN Paul Davis was yesterday discharged from a subpoena requiring him to supply details of 40 former detainees he treated.

The order to testify in the Johannesburg Magistrate's Court followed rejection last year of Davis's application to the Supreme Court to declare invalid the subpoena. A refusal to testify could have sent him to jail.

Davis, of Johannesburg, was required to give details of an article in The Star on September 29 1986.

It quoted an unidentified doctor — Davis — claiming 83% of a group of former detainees aged 14-45 showed evidence of physical abuse.

Davis told the court the issue of curbing assaults in detention was of great importance to him. He had approached the police, presented papers to the National Medical and Dental Association and drawn up guidelines for district surgeons.

The flow of injured detainees seen by him, however, did not diminish.

Davis said the only action left was to tell the Press.

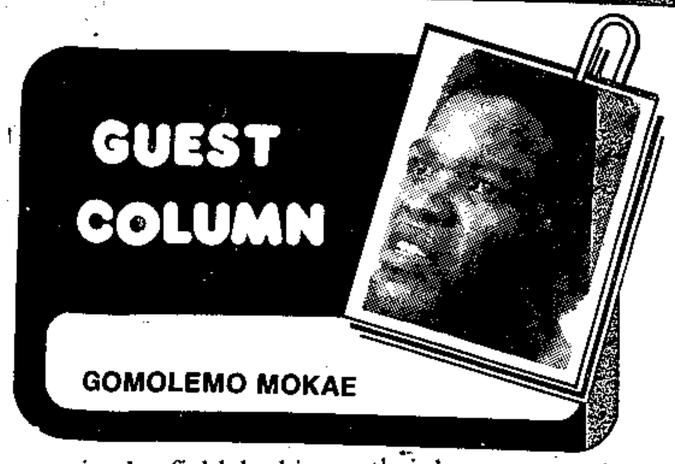
He said the avenue of reporting cases to police was not easy because police did not guarantee detainees' safety.

Davis, asked for detainees' names and addresses, said all the files, except for five personal patients, were the property of the National Medical and Dental Association.

The magistrate discharged him from the subpoena.

UN hopes now a dream for the oppressed

Sowetan 10/2/89 (85)



WE are now almost a decade away from the year 2000, the year the United Nations (UN) has targetted as a deadline for the attainment of "Health for All".

Sadly, it would appear the UN's noble dream is but an illusion.

This is primarily because the privileged classes of this world, basking in the abundant rays of excellent, exclusive health services, are far from being convinced that health, like food, clothes and shelter, is man's basic need.

Locally, the false notion that accessibility to, and availability of health services is a privilege and not a right is tenaciously upheld by the powers-that-be.

Toll gates have been installed along the path to a destiny free of physical and mental affliction, and the poor have been left destitute, unable to pay exhorbitant fees for medical attention.

For the said poor, dreams of "Health for all by the year 2000" have become nightmares with the murder of a panacea of their ailments, Dr Abu-Baker Asvat.

This article is a tribute to Dr Asvat, as well as an appraisal of this country's health scenario. In my mind, the two are mutually inclusive.

It is my strong conviction that health workers should be the most committed of political activists. They, more than anyone else, are witnesses to the destructive effects of this country's racist laws on the oppressed.

They know well the prevalence of diseases of want like kwashiorkor, gastroenteritis and tuberculosis among black infants, and the high mortality therefrom.

They often hopelessly watch demises of black children from rheumatic heart disease, another disease of want whose spread is facilitated by overcrowding.

Medical practitioners annually observe astronomical budgets being allocated for the defence of apartheid when health services for the oppressed cry out for improvement.

They are conversant with the Department of Health and Population Development's obsession with an education for blacks on the merits of family planning, giving little regard to equally (if not more) important campaigns on the merits of regular "pap smears" by women to detect womb cancer early — a cancer which is ravaging hundreds of black women yearly.

They also know that breast cancer, being more common among whites, is paradoxically more fatal among blacks than whites simply because the former present themselves late for medical treatment.

As health practitioners, they need not be informed that this is because there is absolutely no vigorous national campaign educating black women on the merits of regular breast self-examination (BSE) for early detection of and hence fewer deaths from breast cancer.

In the face of all this, many medical practitioners in private practice work like bees providing curative and palliative medicine for the oppressed, enormously enriching themselves in the process.

Their schedule accords them no time for *interventive medicine* – confronting the political cause of their people's ailments.

Their colleagues in hospitals, on the other hand, prioritise ascendence on the academic ladder to their people's political struggle, and hence bury themselves in books exclusively.

Dr Abu-Baker Asvat, in his simple, unassuming manner, was head and shoulders above all of us.

In his blue jeans, Abu was more at home among the downtrodden than in prestigious medical congresses.

While bright sparks stayed in hospital and vigorously looked for "interesting cases" to research on and gain fame by writing in esteemed journals, Abu was in the field locking horns with the inequitable system that was a cause of such "cases".

Abu could never have been a candidate for the Nobel Prize for Medicine. He could never have unearthed an esoteric medical finding that could win him the prize.

Rather, Abu engaged in what any medical school graduate could do; doing "pap smears", screening poor children for rheumatic heart diseases by listening to their hearts, screening for undiagnosed high blood pressure and sugar diabetes among the poor by taking their blood pressures and testing their urines for sugar.

But then it is not every medical school graduate who *does* what Abu was doing, simply because that would thin his/her bank balance. Abu sacrificed his time and money for the downtrodden.

"If you put money as the main object in private practice, you may never have time for community work," I recall him advising me when I joined him at a free health project in Mochaeneng, during my short internship period in Johannesburg.

But to me, Abu's selfless commitment to the cause of the unprivileged was more eloquent than any struggle for a socialist, worker republic of Azania, Abu, in death, deserves the oppressed's noble prize, martyrdom.

Dr ABU-BAKER Asvat gave Vlakfontein families tents after their houses were bulldozed.

BUSINESS

This year's labour flashpoint: Shift work and health

Shift work is as old as industry itself, but it is only recently that its damaging effects on health and social life are coming under scrutiny, reports EDDIE KOCH

BRUTAL assaults, broken families and poor health are just some of the problems experienced by workers as companies resort to increased shiftwork in order to boost ailing productivity, says a recent labour survey.

Unions report the grievances of shiftworkers will become a flashpoint in many sectors of the economy this year. Industrial conflict has already erupted on the floor of a textile factory in the Western Cape over the survey's findings.

"Shiftwork has become a burning issue for organised labour as companies are prevented by sanctions and falling rand values from obtaining new technology and have to keep old machines running 24 hours a day to maintain the levels of production in their plants," says a union organiser.

The Amalgamated Clothing and Textile Workers' Union (Actwusa) and management of the Nettex textile company jointly commissioned an investigation into the attitudes of shiftworkers after a dispute in 1987 over management's plans to add an extra shift to the three-shift cycle that operated in the factory.

According to the union's newspaper, *Actwusa News*, the survey found shiftworkers faced problems ranging from assaults while waiting for public transport in the early hours of the morning to mental exhaustion as a result of continuous work in the factory and at home.

One worker told the researchers she had been attacked, robbed and stripped naked at the railway station while waiting for a train to take her home after the night shift at Nettex had ended, the newspaper said.

Most workers complained that shifts, often worked by both parents in a family, disrupted family relationships, left children unattended to and, in the words of one worker, turned him into a *"vreemdeling in ons huis"* (a stranger in our home).

Other workers said they were often too tired for sex and that this often placed a strain on their marriages.

Health problems derived from the fact that workers' sleep and eating patterns were severely disrupted by shiftwork.

Night work caused eating and digestive problems. This was both because the changes in shift required a change in eating habits and because workers did not have enough time to cook. Some workers complained of regular indigestion and stomach cramps.

Other health problems voiced by those interviewed included:

- More accidents took place at night because the mental strain made shift workers less alert than day workers.
- High noise levels, caused by continuously running machines, resulted in many labourers suffering perpetual headaches. Workers reported headache pills were not allowed into the factory.
- Dust levels in the plant were higher during the night shift because no doors or windows were open and this caused a range of health hazards.

Although the investigation was confined to the Nettex workforce, it highlights the trauma experienced by all shiftworkers. The findings of the survey are backed by studies in other parts of the world.

An increasing number of factories in South Africa are introducing extra shifts in order to increase productivity levels. This is confirmed by a recent report from the Federated Chamber of Industries (FCI) which says spare production capacity is the lowest for six years and urges the government to solve the problem by "investigating forms of incentives that encourage both employers and employees participation in second and third shifts"

The FCI report says the alternative method of boosting production capacity by importing modern technology was ruled out because "dwindling foreign reserves unfortunately prevent the country from embarking on a massive industrialisation process".

Pressures on companies to increase their number of shifts are thus likely to make shiftwork a major item in wage talks this year.

"The only way employers can squeeze more profits out of workers is to keep their machines running for 24 hours a day and to make their employees work longer hours," says Actwusa regional secretary for the Western Cape, Ebrahim Patel.

Meanwhile, the Nettex survey has caused a deadlock in wage negotiations. Management has offered a wage package that includes a fourth shift and has threatened to lock out the workforce if this is not accepted. Workers refuse to accept changes to the existing shift pattern. Actuwsa has asked for a conciliation board to try and break the deadlock.

Launch of national health care group

By Jo-Anne Collinge

A national organisation drawing together about 2 000 professional, para-professional and lay workers in the health care field is to be launched in the Johannesburg City Hall at the weekend.

The organisation, to be called the South African Health Workers' Congress (Sahwco), is an outgrowth of the 10-year-old Health Workers' Association, which has branches in Transvaal, the Free State and the Western Cape, and Natal's Health Workers' Organisation.

Its efforts will be geared at developing health across the segregated and unequal facilities created by apartheid.

The constituent organisations have already been involved in these activities, which they have pursued by educational campaigns, community health projects and medical care in areas of political conflict.

The HWA has for some time rallied around the slogan "Health in the hands of the people". The new organisation will continue to pursue a non-elitest approach to health and to tackle the political issues this raises.

"South Africa probably has one of the most fragmented health services in the world. In the urban areas this results in confusion as to responsibility and competition between different levels (of care) for resources; in inadequate co-ordination; and in duplication or even triplication of services in a wasteful manner," a pamphlet introducing the new organisation observes.

It warns on the likely implications on the privatisation of health care, adding: "The recent increases in hospital and clinic fees have discouraged people from making use of public health facilities."

This, it adds, will have a disasterous effect on the health of working people, the unemployed, old age pensioners and the disabled.

● The launch will be a two-day event. The first day is open to delegates only. The second — Sunday — is an open day.

Boycott will effect doctors' training, warns professor

Medical Reporter

An academic boycott of South Africa will have a long-term detrimental effect on the training of doctors and ultimately on the whole health care service, warns Professor J P van Niekerk of the University of Cape Town.

Professor van Niekerk, Deputy Dean of the university's Medical Faculty, said in a recent article in the South African Medical Journal that in the long-term, any reduction in the interchange of scientific thought and ideas would have this detrimental effect.

He said there had been overseas conferences where it had been made difficult, if not outright unacceptable, for South Africans to attend.

He had encountered academics who were prepared to visit some South African universities but refused to go to others.

The dilemma, he warned, took on another dimension regarding the appointment of overseas academics at local universities.

"The ultimate boycott is reached when people just don't want to come because it is just not worth their while," he said.

Dr Philip van Heerden, president of the Medical Research Council, said the boycott had not had severe repercussions in the research field as yet.

New health union launched

HEALTH care shed its white coat image yesterday when the South African Health Workers' Congress was launched in the Johannesburg City Hall to the accompaniment of freedom songs, traditional dancing and endorsements from scores of community organisations and trade unions.

Sahwco, with an estimated membership of 2000, draws together doctors, nurses, paramedical and auxiliary health staff as well as lay people whose interest lies in the improvement of health facilities.

Exciting

The second day of its inaugural meeting was open to the public and drew a crowd of well over 1000. Mr Krish Vallabjhee was elected president.

"The exciting thing is that it's the people at this launch who are talking about health. We've allowed the professionals to control health, to take it out of our hands," said Dr Ivan Toms, who was active in community health projects in the Cape Peninsula long before his objection to military service brought him national prominence.

Vital

Dr Toms said Sahwco could play a vital role in "demystifying" health. Medical knowledge, shared with the people, could save lives. Health workers should revise their concept of themselves, should see themselves as part of a team "passing on their skills and empowering other people."

Various speakers emphasised the link between economic systems and the health of the people. They referred to poor health having its roots in landlessness, homelessness and unemployment. — *Sowetan Correspondent.*

Health care becomes everyone's property

By Jo-Anne Collinge and Sally Sealey

Health care shed its white-coat image yesterday when the South African Health Workers' Congress was launched in the Johannesburg City Hall to the accompaniment of freedom songs, traditional dancing and endorsements from scores of community organisations and trade unions.

Sahwco, with an estimated membership of 2 000, draws together doctors, nurses, para-medical and auxiliary health staff and lay people whose interest lies in the improvement of health facilities.

The second day of its inaugural meeting was open to the public and drew a crowd of well over 1 000. Mr Krish Vallabjhee was elected president.

"The exciting thing is that it's the people at this launch who are talking about health. We've allowed the professionals to control health, to take it out of our hands," said Dr Ivan Toms, who was active in community health projects in the Cape Peninsula long before his objection to military service brought him national prominence.

Dr Toms said Sahwco could play a vital role in "demystifying" health.

Medical knowledge, shared with the people, could save lives. Health workers should revise their concept of themselves, should see themselves as part of a team "passing on their skills and empowering other people".

Speakers emphasisedthe link between economic systems and the health of the people. They referred to poor health having its roots in landlessness, homelessness and unemployment.

Father Smangaliso Mkhatshwa, general secretary of the Institute for Contextual Theology, pointed to the uphill job of health workers in a context of increasing poverty and "brutal and terrible stress" caused by repression.

Health authorities to thrash out differences

85 Stan 6/3/89

By Toni Younghusband,
Medical Reporter

Health authorities are being invited to thrash out their differences and discuss possible solutions for South Africa's crumbling health care system at a conference later this year.

The conference, the brainchild of Wits University's Centre for the Study of Health Policy, has been organised in the wake of widespread dissatisfaction over escalating health costs and inferior health service.

Medical aid societies and private hospital owners, who have been locked in battle over tariffs, will be encouraged to attend the conference and to present papers.

High drug costs, another explosive issue which had pharmacists, manufacturers and the Government at loggerheads earlier this year, will also be on the conference agenda.

WHOLE SYSTEM THREATENED

"Health care costs are going through the roof. Some people blame private doctors and hospitals, others blame the medical aids. Yet others blame the multinational drug companies or the Government.

"Spiralling health care costs affect everyone and threaten the whole health care system. We would like to host an academic conference where the causes of escalating costs can be identified and short-term solutions found," conference organiser, Mr Cedric de Beer said.

Mr De Beer said the conference would be open to anyone involved in health care to attend.

The conference will be chaired by economic and health economy experts who will comment on each topic.

A date for the conference has not yet been set as the organisers are trying to get hold of an overseas speaker.

Ruling on medical co-operation challenged

Star 9/1/78

Pretoria Correspondent

The ruling which prevents a medical practitioner from rendering services to, or co-operating with, a registered chiropractor or homeopath, was challenged in the Pretoria Supreme Court yesterday.

The application was brought by Dr Mario Milani, chairman of the South African Associated Health Service Professions Board, against the South African Medical and Dental Council and the Minister of National Health and Population Development.

APPROVED

In it, Dr Milani said the ruling should be declared null and void.

The ruling was made by the council and approved by the Minister on December 3 1976.

The board claimed the ruling frustrated its practice and was not in the public interest. A chiropractor or homeopath would not be able to fulfill his task competently if he could not obtain information from a doctor who had previously treated a patient.

In court papers, the board said it was duty-bound by statute to assist in the promotion of the health of the population and to set standards for the training of practitioners, but the effect of the rule inhibited it from attaining these objectives.

"The rule is not restricted to simply collaborating or participating with a chiropractor or homeopath in the treatment of a patient, it prohibits a medical practitioner from even telling a homeopath, whom a patient has consulted, what treatment has been administered in the past or providing any medical history," Dr Milani said.

The council, opposing the application, argued it was not in the public interest for medical practitioners to co-operate with chiropractors or homeopaths because they were not as qualified as medical practitioners.

Mr Justice Eloff, the Deputy Judge President of the Transvaal, will pass judgment today.

Star 10/3/89. 85

Bill to make human tissue available

A Bill authorising the Director-General of National Health and Population Development to make available human tissue in the absence of a donation was introduced yesterday.

The Human Tissue Amendment Bill also provides that:

- It be placed beyond all doubt that the furnishing of donated tissue by institutions or persons to other institutions or persons is legal, and that any university or technikon is entitled to receive donations.
- Provisions on the removal of human tissue at inquests are extended so as to cover any post-mortem examination.
- The power to grant authority regarding the removal of human tissue is extended to any authorised magistrate.
- The removal of gametes and certain tissue from the bodies of minors is prohibited.
- Sanctions regarding the illegal importation of human tissue are extended, and all such imports and exports are to be subject to a permit being issued.
- Investigating officers can be appointed on an ad hoc basis.
- Artificial fertilisation is to be regulated to achieve more flexibility. Existing provisions are repealed. — Sapa.

'Doctors can't assist natural healers, court rules

Pretoria Correspondent

Medical practitioners may not assist or co-operate with chiropractors or homeopaths, the Pretoria Supreme Court has ruled.

Mr Justice Eloff, the Deputy Judge President of the Transvaal, dismissed with costs an application to have a SA Medical and Dental Council's ruling against practitioners providing services to, or co-operating with, a registered chiropractor or homeopath declared invalid.

The application was brought by Dr Mario Milani, chairman of the South African Associated Health Services Professions Board, against the council and the Minister of National Health and Population Development.

Dr Milani, a chiropractor, said in court papers the ruling made by the council should be declared null and void.

TREATMENT

The rules were made by the SAMDC and approved by the Minister on December 3 1976.

The board claimed that the ruling frustrated their practice and was not in the public interest because a chiropractor or homeopath treating a patient would not be able to fulfil his task competently if he could not obtain information from a doctor who had previously treated the patient.

It said it was duty bound by statute to assist in the promotion of the health of the population and to set standards for the training of practitioners, but the effect of the rule inhibited it in attaining these objectives.

The Medical Council argued that it was not in the public interest for chiropractors or homeopaths were not as qualified as medical practitioners.

Mr Justice Eloff granted the board leave to appeal.

Masa against medicine GST

Star 14/3/87

The Medical Association of South Africa (Masa) said last night it was disappointed the Minister of Finance had not abolished General Sales Tax on medicine in this year's budget.

A spokesman for Masa said the association had made repeated calls for the abolition of GST on medicine and would once again approach Mr du Plessis — Medical Reporter.

3. Application dismissed by Supreme Court.

EXECUTIVE DIRECTORS OF PROVINCIAL HOSPITAL SERVICES

CAPE PROVINCIAL ADMINISTRATION

(1) (b) (i) Yes (16)

(ii) Yes (13)

(aa) 1987:

1. Loss of four fingers.
2. Fell on way from bathroom.
3. Fell out of hospital bed.
4. Internal bleeding after operation.
5. Injuries sustained after fall in hospital.
6. Unsuccessful sterilisation.
7. Buzzing sound in ear after injection.
8. Complications after head injuries sustained in a motor vehicle accident.
9. Unsuccessful treatment.
10. Stillborn baby.
11. Renal failure after treatment for backache.
12. Scissors left in stomach after operation.
13. Lesions of the skin.
14. Damages after caesar ean section under epidural anaesthetic.
15. Metallic foreign body left in buttock.
16. Death due to brain damage after tonsillectomy.

1988: 1. Stillborn baby.
2. Allergic reaction due to administration of drug.
3. Complications after operation on ankle.
4. Dysphasia due to thrombosis after catheterisation procedure.
5. Post-operative complications.
6. Fruitless expenditure due to postponement of operation.
7. Stillborn baby.
8. Strangulated spermatic cord after hernia procedure.
9. Incorrect diagnosis.
10. Pain and suffering due to delayed diagnosis for mastectomy.
11. Bad treatment.
12. Faulty machine during operation.
13. Testicle biopsy without permission.

(bb) 1987:

1. Settled out-of-court.
2. Case was withdrawn.
3. Case pending.
4. Case was withdrawn.
5. Settled out-of-court.
6. Settled out-of-court.
7. Case pending.
8. Case was withdrawn.
9. Case was withdrawn.
10. Case was withdrawn.
11. Case was withdrawn.
12. Settled out-of-court.
13. Case pending.
14. Case pending.
15. Case was withdrawn.
16. Case pending.

1988: 1–13 Cases pending.

NATAL PROVINCIAL ADMINISTRATION

(1) (b) (i) Yes (1)

(ii) Yes (1)

(aa) 1987

1. Omitted sterilisation at Caesarean section and subsequent live birth.

1988 1. Unattended birth.

(bb) 1987

1. R27 000,00 awarded subject to appeal.

1988 1. Out-of-court settlement.

ORANGE FREE STATE PROVINCIAL ADMINISTRATION

(1) (b) (i) Yes (4)

(ii) Yes (6)

(aa) 1987:

1. Sustained brain damage during operation.
2. Permanent damage to leg as a result of too tight plaster cast.
3. Injury to buttock as a result of an injection with an infected needle.
4. Death due to burns.

1988: 1. Legs paralysed as a result of incorrect treatment after a coronary by-pass operation.
2. Needle left in kidney.
3. Death due to lack of treatment in casualty ward.
4. Fell on hospital floor.
5. Permanent disability of shoulders and elbows as a result of incorrect treatment.
6. Skin burns during operation.

(bb) 1987

1. Case pending.
2. Case pending.
3. Case pending.
4. Out-of-court settlement.

1988: 1. Case pending.
2. Case pending.
3. Case pending.
4. Case pending.
5. Case pending.
6. Case pending.

TRANSVAAL PROVINCIAL ADMINISTRATION

(1) (b) (i) Yes (18)

(ii) Yes (14)

(aa) 1987:

1. Brain damage suffered during induction of anaesthetic.
2. Diathermy burn on buttock.
3. Instrument left in abdomen.
4. Displacement of arm.
5. Paralysis due to fracture of T8 vertebra.
6. Intoxicated patient died after treatment of apparently less serious stab wounds.
7. Drainage pipe left in abdomen.
8. Mini sterilisation was followed by a pregnancy.
9. Extensive burns during pre-operative preparation of the skin.
10. Reduced eye sight due to infection setting in because of delayed transfer from one hospital to another.
11. Infection due to being discharged after giving birth without suturing the episiotomy.
12. Left facial nerve palsy after tympanotomy for reduced hearing on the left side.
13. Strike by General Assistants.
14. Appointment of applicant as Senior House Officer.
15. Transfer of Senior Superintendent.
16. Loss of two teeth caused by anaesthetic procedure.
17. Strike by General Assistants.
18. Strike by General Assistants.

1988: 1. Internal injuries due to fall out of bed.
2. Brain damage caused by administered medication.
3. Multiple operations to restore skin lesions caused by failure to remove a drainage tube.
4. Death as a result of a penicillin injection.
5. Burn on scapula caused

Hansard.

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Lawsuits against Minister

40. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether any lawsuits were brought against (a) him in his capacity as Minister of National Health and Population Development and/or (b) any specified chief executive director of provincial hospital services in (i) 1987 and (ii) 1988; if so, what (aa) were the circumstances of each lawsuit and (bb) was the outcome in each case;

(2) whether (a) he and/or (b) any specified chief executive director of provincial hospital services paid out any money (i) as a result of successful lawsuits brought against them and (ii) in out-of-court settlements in each of the above years; if so, what amount in respect of each case?

B97E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) (i) Yes (4)

(ii) Yes (3)

(aa) 1987

1. Application for an order setting aside a decision in terms of which 16 containers of imported mechanically deboned poultry were released from detention and declared fit for sale.
2. Application for an order setting aside the decision of the Director-General to dismiss the Applicants from their employment.
3. Application for an order declaring that on a proper interpretation of Rules 9(1) and 9(2) of the Rules of Conduct for Medical Practitioners and Dentists, it is permissible for medical practitioners and dentists to co-operate with practitioners registered as such under the Associated Health Service Professions Act, 1982, in respect of medical or health treatment of a particular patient.
4. Damages for injury of name and reputation (R25 000,00) and special damages for loss of income (R6 800 000,00).

1988: 1. Application for the release of a person detained at Weskoppies Hospital.
2. Application for an order declaring that Applicant is an associated institution for the purposes of the Associated Institutions Pension Fund Act, 1963.
3. Application for an order declaring that Applicant be permitted to collect contributions from the public in terms of section 4 of the Fund Raising Act, 1978.

(bb) 1987:

1. Application dismissed.
2. Applicants did not proceed with the case.
3. The Minister is the second respondent, and will not oppose the application and will abide by the judgement of the Court.
4. Case pending.

1988: 1. Application dismissed.
2. Out-of-court settlement — no costs.

by theatre equipment during operation.
6. Injury due to inadequate supervision.
7. Contracted Aids following blood transfusions.
8. Wound sepsis caused by inadequate treatment after operation.
9. Insufficient plaster-of-Paris applied to left forearm.
10. Inadequate treatment.
11. Injured in ambulance in transit from the hospital to home.
12. Injury to right hip due to fall from ambulance trolley.
13. Fractured rib sustained from falling off ambulance stretcher.
14. Paralysed right arm due to faulty traction.

(bb) 1987

1. Case pending.
2. Case pending.
3. Case pending.
4. Case pending.
5. Case pending.
6. Case pending.
7. Court ruling in favour of Plaintiff.
8. Case pending.
9. Case pending.
10. Case pending.
11. Case pending.
12. Case pending.
13. Case pending.
14. Order in favour of Applicant — on appeal at present.
15. Case pending.
16. Case pending.
17. First case by four employees was dismissed with costs. In the second case the Supreme Court ruled that the audi alteram partem rule was not applied properly and that the workers had to be reinstated. This case is on appeal at present.
18. As the audi alteram partem rule with regard to the legitimate expectation of a pension at the age of sixty was not applied the Supreme Court ruled that the strikers belonging to a pension fund had to be reinstated. Since the ruling the audi alteram partem rule was applied and at present a further case is sub judice.

1988
1. Case settled.
2. Case pending.
3. Case settled.
4. Case pending.
5. Case pending.
6. Case pending.
7. Case pending.
8. Case pending.
9. Case pending.
10. Case pending.
11. State Attorney is of the opinion that the Town Council of Johannesburg is responsible. State Attorney regards case as closed.
12. Case pending.
13. Case settled.
14. Case pending.

(2) (a) MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(i) No money was paid out.

(ii) No money was paid out.

(b) EXECUTIVE DIRECTORS OF PROVINCIAL HOSPITAL SERVICES

CAPE PROVINCIAL ADMINISTRATION

(i) No.

(ii) Yes.
1987: 1. R20 000,00.
5. R 7 500,00.
6. R 1 000,00.
12. R 2 000,00.
1988: None.

NATAL PROVINCIAL ADMINISTRATION

(i) No.

(ii) Yes.
1988: 1. R4 500,00.

ORANGE FREE STATE PROVINCIAL ADMINISTRATION

(i) No.

(ii) Yes.
1987: 4. R392,50.

OTHER CLAIMS SETTLED OUT-OF-COURT DURING 1987

1. Plaintiff claimed during 1985 — settled in 1987 — R6 832,00.
2. Plaintiff claimed during 1986 — settled in 1987 — R5 979,20.
3. Plaintiff claimed during 1986 — settled in 1987 — R7 000,00.
4. Plaintiff claimed during 1986 — offer of R600,00 was made but has not been accepted yet.

TRANSVAAL PROVINCIAL ADMINISTRATION

(i) Yes.
1987: 7 R818,42

(ii) Yes.
1987: None.

1988: 1. R1 650,00.
3. R 266,70.
13. R1 000,00.

Other successful lawsuits brought against the Administrator of the Transvaal.

1987: R15 000,00.
1988: R 3 313,00.

Other lawsuits brought against the Administrator of the Transvaal and settled out-of-court.

1987: R1 120,00
R1 000,00
R2 750,00.

1988: R25 000,00
R40 000,00
R 4 908,17
R 1 000,00
R20 000,00.

Language Monument Fund: reserve amount

53. Mr A GERBER asked the Minister of National Education:†

(1) Whether, after the erection of the Language Monument in Paarl, there was a reserve amount in the Language Monument Fund; if so, what was this amount;

(2) whether any allocations have been made to institutions from this reserve fund; if so, (a) to which institutions, (b) what amounts, (c) for what purpose, and (d) when, in each case;

(3) whether there is a body which exercises control over this fund; if so, (a) what body, (b) who are the members of this body, (c) (i) by whom, (ii) when and (iii) for what period have they been appointed and (d) to whom do they report;

(4) what is the current position of the fund?

B146E

The MINISTER OF NATIONAL EDUCATION:

The "Afrikaanse Taalmonumentfonds", which consisted of contributions collected by a committee, was used to establish the Afrikaans Language Monument. After the handing over of the Afrikaans Language Monument and the Afrikaans Language Museum to the State in 1977, the "Afrikaanse Taalfonds" was established. The "Fonds" *inter alia* administers the remaining funds of the "Afrikaanse Taalmonumentfonds". The "Fonds" is an organisation that administers its affairs in terms of its own constitution. Particulars regarding the "Afrikaanse Taalfonds" and its activities should therefore be obtained from that organisation itself.

Medunsa: students qualified as doctors

56. Dr M S BARNARD asked the Minister of Education and Development Aid:

How many students in each race group qualified as doctors at the Medical University of Southern Africa at the end of 1988?

B155E

Health sector prospects are perking up

GERALD REILLY

PRETORIA — Health sector organisations are said to believe government's privatisation and deregulation policy would create more competition with cheaper medicine and health care.

A Health Department spokesman said yesterday this was agreed with health sector organisations, although reductions in the prices of medicines was a complex and sensitive matter.

The Competition Board has been asked to investigate the feasibility of the sector working only from published prices based on quantities. The misuse of bonuses and samples was condemned.

These items were agreed at talks last week between the Department of Health, Medical Association of SA, the SA Pharmaceutical Association, SA Association of Retail Pharmacists, National Wholesale Druggists' Association, pharmaceutical suppliers and private hospitals.

The Pharmaceutical Council was considering amendments to ethical rules to curb misuse.

It also said price controls were undesirable and could be counter-productive.

Private hospital representatives explained why some hospitals had contracted out. They said the provision of medical services, according to Reserve Bank statistics, rose in 1983-87 by 49,7%.

In the same period pharmaceutical and allied surgical products increased by 96,3%, services by 71,1% and all goods and services by 78,5%.

Restaurateurs object to smoking ruling

By ANTHONY DOMAN, Municipal Reporter

ALL but a handful of the Peninsula's restaurateurs have signed a petition "most vehemently" attacking Cape Town City Council's controversial moves to enforce non-smoking in restaurants.

A total of 307, including major fast food chains, have signed the petition, drawn up under the auspices of the Federated Hotel, Liquor and Catering Association of South Africa (Fedhasa).

Nine refused to sign.

The council has passed a by-law which will create compulsory no-smoking areas in restaurants. Objectors have until April 13 to lodge their views in writing.

Smoking is already banned in certain areas such as cinema auditoriums and the lower decks of buses.

The final decision on the by-law rests with the Provincial Administration.

The petition was delivered to the Mayor's Office today.

It calls for the retention of the existing rights of the hotelier or restaurateur and objects to the proposed by-law.

Members object to the infringement of their right to decide how to receive and accommodate clients in their businesses.

"We believe that there should be no further restrictions on the freedom of the individual," they say.

Poor impression

"We object to the fact that any client can call in the police to have an offending smoker arrested.

"We are most concerned about the poor impression it would make, in particular on foreign clients, if they were subjected to such treatment."

In a covering letter, Fedhasa's Western Cape chairman, Mr Angus Dodds, says the organisation objected "most vehemently".

It demanded that its members enjoy their rights as entrepreneurs "to run their businesses as they see fit, welcome whom they please, under conditions that satisfy their paying guests, not the local authority".

"How do you fulfil the role of mine host when you run the risk of a law enforcment officer being summoned to remove one of your guests?

"Surely there are more important functions for the police than policing smoking in restaurants?" he asks.

Tourism was Cape Town's most important revenue earner and job creator, according to Mr Dodds.

"Surely it would be suicidal to impede this by unilateral

(Turn to page 3, col 7)

INSIDE:

Smoking row

(Contd from Page 1)

regulations against the freedom of our guests to our city and area?"

All should be encouraged to move towards deregulation and towards respecting the free movement of people from all over the world.

"Cape Town has a proud history of playing host to the world, in the liberal traditions, well-known throughout the years," he says.

"This record should not be blemished under any circumstances."

● Details of the by-law are available for inspection during office hours at the amenities and health committee office, 5th floor, podium block, Cape Town civic centre.

Smoking or health: choice is ours

CAPE TIMES 30/3/89

THIS article, jointly prepared by DEREK YACH of the National Council on Smoking and Health, RIKA DE RUITER of the Heart Foundation of Southern Africa and CARL ALBRECHT of the National Cancer Association, calls for support for Cape Town City Council in applying smoking controls.

THE World Health Organisation regards smoking as the single most preventable cause of death and disease globally. Since the 1960s, thousands of research reports have documented the direct and, more recently, indirect impact that smoking has on health.

The quality of research evidence is questioned by the tobacco industry, which often quotes outdated individual studies (or healthy smokers) as evidence that smoking and health are not related.

Researchers, however, assess causal relationships on the basis of three decades of consistent results obtained from the vast bulk of studies. These results have not been dislodged in the face of diversity of time, place, people and methods used.

Initially, studies relied on death certificates and people's history of smoking. The last decade has seen growing sophistication in the measurement of smoking and disease which has produced similar results to earlier studies.

Indirect effects

In South Africa, about a third of all deaths among whites are attributable to smoking-related diseases (mainly cardio vascular diseases, lung cancer and chronic lung disease), a quarter among Asians, an eighth among coloureds and a twentieth among blacks. The proportions among coloureds and blacks are likely to rapidly increase as childhood death rates decline.

Smoking causes indirect as well as direct effects. Studies have shown that babies born to smoking mothers are of lower birthweight. In addition, children of smoking parents have more respiratory disease. Non-smokers exposed to smokers' smoke have been shown to have increased risks of lung cancer. These findings mean that smoking can no longer be regarded as merely of nuisance value to non-smokers, who are forced into "passive smoking" in public places.

Smoking trends in South Africa indicate higher smoking rates among urban than rural people and higher male than female rates. The lowest smoking rates are found among the poorest sectors of the community. Increases in income tend to be associated with increases in smoking up to abouty R1 000 a month (1984 standards) or 8-10 years of schooling.

Further increases then tend to be associated with declines in smoking, probably because health education messages start to get through. Smoking rates among black men and boys are already as high as among whites and coloureds.

Given the current high levels and expected impact of smoking, public health professionals not only have a right, but an obligation, to take action.

An overall smoking policy should aim to prevent non-smokers starting (particularly children), protect the rights of non-smokers (including children and the unborn), help smokers to quit (and not victimise them) and, most importantly, create a social environment in which smoking is regarded as abnormal, just as spitting is today.

Social environment

Legislation at national and local level is needed to support these goals. The tobacco industry maintains that individuals are free to choose whether to start. However, the influences of unopposed advertising, peer pressure and physical addiction of the habit itself restrict absolute freedom. (Many heavy smokers, subject since childhood to these factors, cannot be held entirely responsible for their habit.)

Tobacco companies sell not only a product but an unhealthy, addictive lifestyle.

Legislation is particularly important with respect to banning advertising of tobacco products, and is supported by more than 30 countries globally as well as by the World Health Organisation. Current voluntary agreements in South Africa between the Government and the industry have failed to effectively restrict advertising.

The industry specifically aims at urbanising black and coloured communities through its emphasis on radio and billboard advertising and children (in spite of denials) through the support of cinema advertising and sports sponsorship.

Tax increase

Economic interventions at national level are urgently required. Recent overseas reviews have indicated that a 10% increase in the taxation on cigarettes would result in a decrease of 6% in consumption. In South Africa such price increases are particularly important as a means of deterring potential smokers.

We recommend a tax increase of 25% which would be translated into an increase of about 8-10% in the packet price. This is in sharp contrast to the 1,4% included in the 1989 Budget at a time when cigarettes are already underpriced relative to other products. The increased tax raised could be used to meet losses incurred by the media through a ban on advertising and to support sport.

The overall economic effects of smoking in South Africa have recently been reviewed. The analysis indicates that the economic benefits to the country from smoking are outweighed by the costs.

Fundamental curricular changes are required at school level to promote healthy lifestyles, of which not smoking would be one key component. Such strategies need to be given the highest priority and need to take place within a social environment that no longer supports smoking as socially desirable.

Rapid compliance

Mass media campaigns are effective not only in decreasing the proportion of smokers but in supporting non-smokers and ex-smokers. In this context, legislation aimed at restricting smoking in restaurants and public places is critical in raising the level of public awareness that the dangers of smoking are more than simply a nuisance.

Legislation which banned smoking in public places in New York City more than a year ago resulted in rapid city-wide compliance and support.

A smoking policy must be applied at a national and city level. Cape Town needs to set clear targets that can realistically be achieved. A target of a smoking rate of no more than 15% of the population by 2000 is realistic, provided policymakers are able to act in the best interest of the future public health of the city.

Cape Town has already taken the lead and the city council should be supported in its attempts to move faster and more boldly along this road. Private corporations in the city, insurance agencies, Groote Schuur Hospital and the UCT Medical School have all recently instituted smoking control policies.

In the end the issue of smoking and health will not be settled by statistics but by political decisions at local and national level. These decisions should and could be influenced by public comment.

Council curbs employees' smoking

CAPE TIMES 31/3/89

By PETER DENNEHY

CAPE TOWN City Council has committed itself to a policy of "actively discouraging" smoking, and resolved that its employees may no longer smoke while attending to members of the public, with immediate effect.

Councillors also voted 17-12 to ban smoking during their own committee meetings.

These motions were adopted among several others on smoking yesterday "to keep the council's own house in order" while passing some recommendations from a report it had commissioned from its Medical Officer of Health, Dr Michael Popkiss.

The council also reaffirmed a decision it took almost exactly a year ago that the advertising of tobacco products should be prohibited on council-owned buildings and properties. This does not apply to bus shelters where contracts had already been entered into.

Exco did not see its way clear to endorsing such "activism", but Mr Llewellyn van Wyk pointed out that the council had sent out warnings about Aids and sexually transmitted diseases, so it should do the same for smoking.

However, Mrs Eulalie Stott's suggestion that smoking should be banned in the Civic Centre was rejected, partly because of anticipated objections from the unions, and partly because many council employees would smoke in the toilets "like schoolboys".

Mr Frank van der Velde said he found it "unpalatable" that a man of Dr Anton Rupert's stature had reacted to an earlier City Council decision in principle (to ban smoking in part of restaurants) by "offering or withdrawing money".

Mrs Joan Kantey expressed dismay that the council appeared to be introducing regulations "merely to use this council as a forum to educate the public".

REPUBLIC OF SOUTH AFRICA

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Vol. 285 PRETORIA, 31 MARCH MAART 1989 No. 11792

PROCLAMATION

by the Acting

State President of the Republic of South Africa

No. R. 34, 1989

HEALTH MATTERS.—BLACK AREAS

Under the powers vested in me by section 25 (1) of the Black Administration Act, 1927 (Act 38 of 1927), read with section 21 (1) of the Development Trust and Land Act, 1936 (Act 18 of 1936), I hereby declare as follows:

1. In this Proclamation, unless the context otherwise indicates—

"Black area" means any area consisting of land referred to in section 21 (1) of the Development Trust and Land Act, 1936 (Act 18 of 1936), or any scheduled Black area as defined in that Act, but excluding the self-governing territories referred to in section 26 of the National States Constitution Act, 1971 (Act 21 of 1971);

"Minister" means the Minister of Education and Development Aid; and

"the Act" means the Health Act, 1977 (Act 63 of 1977).

2. Notwithstanding the provisions of any law but subject to the provisions of this Proclamation, all powers, functions and duties affecting health matters in respect of Blacks in any Black area shall be under the control of the Minister.

3. The provisions of any ordinance of a provincial council or any other law relating to the establishment, maintenance and management of hospitals shall, in so far as they relate to any hospital in a Black area, continue to be of force and effect in respect of that hospital: Provided that any power, function or duty conferred or imposed by any such provision upon an Administrator of a province or an officer or employee of a provincial administration shall be exercised or performed by the Minister or by an officer or employee of the Public Service or provincial administration acting under the authority and instructions of the Minister.

PROKLAMASIE

van die Waarnemende

Staatspresident van die Republiek van Suid-Afrika

No. R. 34, 1989

GESONDHEIDSAANGELEENTHEDE.—SWART GEBIEDE

Kragtens die bevoegdheid my verleen by artikel 25 (1) van die Swart Administrasie Wet, 1927 (Wet 38 van 1927), gelees met artikel 21 (1) van die Ontwikkelingstrust en Grond Wet, 1936 (Wet 18 van 1936), verklaar ek hierby soos volg:

1. In hierdie Proklamasie, tensy uit die samehang anders blyk, beteken—

"Minister" die Minister van Onderwys en Ontwikkelingshulp;

"Swart gebied" 'n gebied bestaande uit grond bedoel in artikel 21 (1) van die Ontwikkelingstrust en Grond Wet, 1936 (Wet 18 van 1936), of 'n afgesonderde Swart gebied soos in daardie Wet omskryf, met uitsluiting van die selfregerende gebiede soos bedoel in artikel 26 van die Grondwet van die Nasionale State, 1971 (Wet 21 van 1971); en

"die Wet" die Wet op Gesondheid, 1977 (Wet 63 van 1977).

2. Nieteenstaande die bepalings van enige wet, maar behoudens die bepalings van hierdie Proklamasie, is alle bevoegdhede, werksaamhede en pligte rakende gesondheidsaangeleenthede in verband met Swartes in 'n Swart gebied onder die beheer van die Minister.

3. Die bepalings van enige ordonnansie van 'n provinsiale raad of enige ander wet met betrekking tot die stigting, instandhouding en bestuur van hospitale bly vir sover dit betrekking het op enige hospitaal in 'n Swart gebied van krag ten opsigte van daardie hospitaal: Met dien verstande dat enige bevoegdheid, werksaamheid of plig wat by so 'n bepaling aan 'n Administrateur van 'n provinsie of 'n beampte of werknemer van 'n povinsiale administrasie verleen of opgedra is, deur die Minister of deur 'n beampte of werknemer van die Staatsdiens of provinsiale administrasie, handelende kragtens die gesag en opdragte van die Minister, uitgeoefen of verrig word.

the allocation of resources," the association said.

'An integrated economy vital for SA'

THE structural changes necessary for full development must include substantial shifts in distribution of income in the direction of low income households, more labour intensive methods of production, wage rates and inflation, a greater decentralisation of control of production, employment and business generally, argued Theo Rudman, director of the Self-Employment Institute, in a speech to the Cape Town Press Club recently.

We must have a much greater role for the small businessmen with, of course, less government regulation of business behaviour.

Most business activity in South Africa has until recentlty been geared to the needs and abilities of the country's First World population.

The much larger Third World population contributed to and benefited from this process of growth to a limited extent due to the social framework of separate economic development created over generations.

According to the deputy governor of the SA Reserve Bank, Dr JA Lombard, this framework, as the foundation of official policy, has recently been abandoned.

As pointed out in the recently published Second Carnegie Inquiry into Poverty and Development in Southern Africa, the problem of under-development facing South Africa is both immense and urgent.

Here are excerpts from a recent speech on the issue by Self-Employment Institute director THEO RUDMAN:

Savings from high per capita incomes cannot be fully applied profitably to domestic capital formation. The First World population is too small and stationary to support cost-effective investments in the development of high technology systems for future domestic application.

This led to a high propensity to import consumer goods or to apply savings to investments abroad wherever possible.

Add to these purely socio-economic considerations the high tax rate, implications of a socio-political system which requires increasing government consumption resources without much growth in the resource and tax base.

The result of such circumstances, if they were real, could well be domestic stagnation of economic activity.

To integrate our Third World economy with our First World economy is, I believe, vital if South Africa is to prosper and develop.

This integration could provide a "shot in the arm" to our ailing formal economy in the absence of foreign investment.

In my view, the most effective way to integrate the two economies is through the centre satellite system.

Foreign organisations should have the opportunity to support, develop and improve the position of the underprivileged people in Southern Africa by making straight donations to organisations that could set up and run certain centre satellite centres or by importing from these organisations.

The unrestricted integration of the First and Third World economies out of basic economics would quickly free this huge hidden wealth.

It would turn our black population from what many people see as a huge liability into an ernormous asset.

By freeing the informal sector and allowing business to be operated more easily and economically South Africa would really take off and be the economic giant it has so far failed to be.

By freeing small formal businesses and the informal sector, and removing monopolistic protection from big companies through control or marketing boards, big business would be forced to be as productive and efficient as possible.

They would see that it would be vital to their survival to use small enterprises as an important part of their business activity.

This would enable big business to reduce its capital and running costs.

These proposals could easily form part of the recovery package that would put South Africa on the high road – where productivity and national pride by all race groups, and a striving for real excellence would be the order of the day.

85

Let's talk health

New order before better care

By CONNIE MOLUSI

WHILE the world celebrates United Nations' International Health Day, South Africans decry the divided and inequitable distribution of health services and resources.

The view of the South African Health Workers Congress (SAHWCO) is that: "The majority of the people are shut off from any real part in the political decision making and cannot take part in the distribution of health resources or the design and development of health services."

The establishment of an adequate health service available to all South Africans can only be realised in a new social order which will provide employment, decent housing, living wages and a free and accessible health service.

South Africa has one of the most fragmented health services in the world. In the urban areas this has resulted in confusion regarding responsibility, competition between different levels for resources, inadequate co-ordination and the duplication of services.

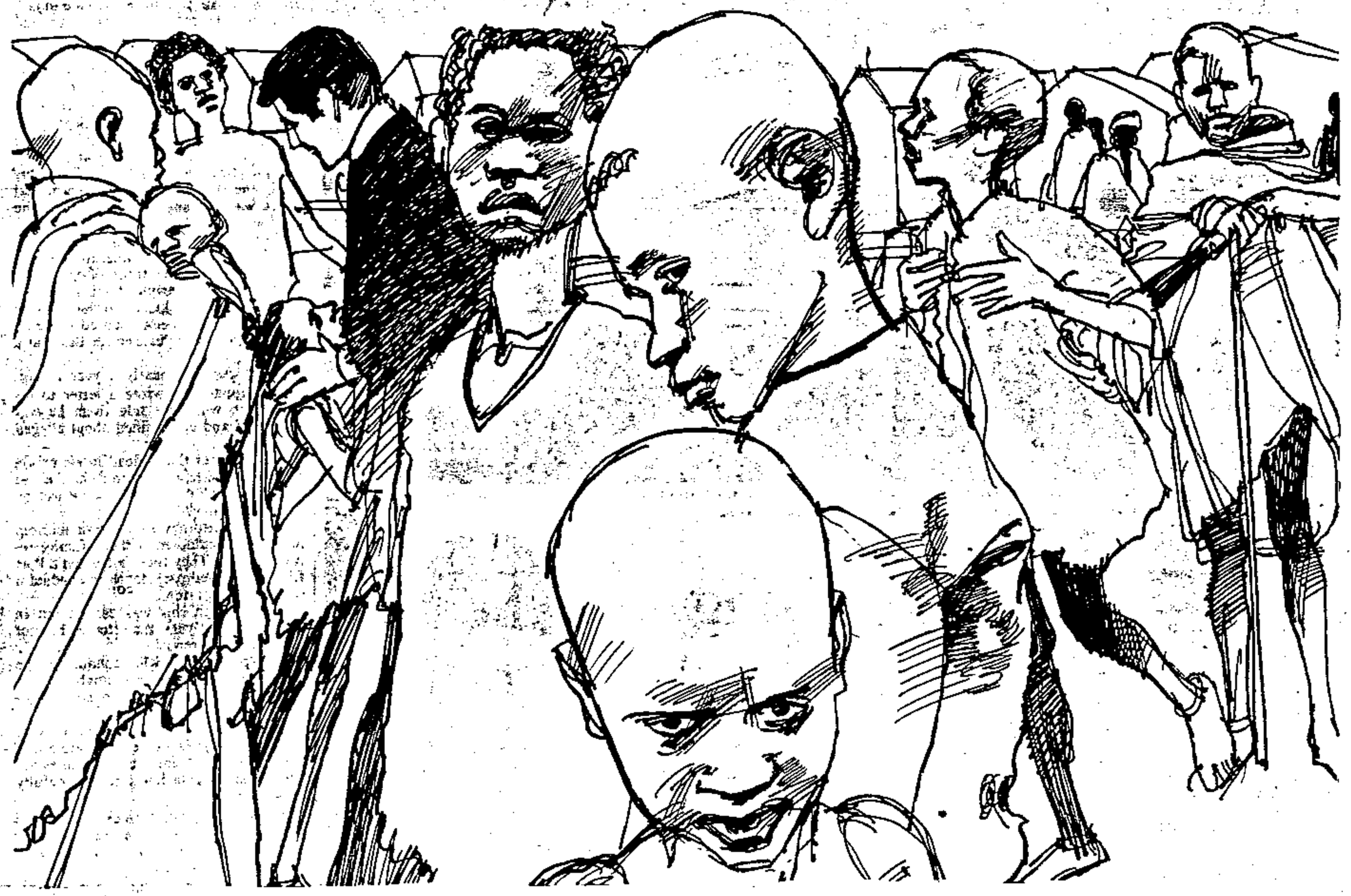
Today is World Health Day. One of the most important things in life is to be healthy.

"On the eve of the 21st century," says director-general of the World Health Organisation Dr Hiroshi Nakajima, "it becomes more and more clear that health goes hand-in-hand with economic and social development.

"In order to survive, the world must adopt healthier ways of living.

"I have decided to devote World Health Day 1989 to the theme of communication for health.

"Health is our most precious possession. "Let us communicate health rather than disease. Let's talk health!"



FOR CHILDREN:
☐ Learn about yourself – understand how your body is changing and growing.
☐ Keep your body clean – you are re-

Do's and

☐ Drink right – you need at least two litres of liquid a day – mostly water. Alcohol can be especially harmful to you and the foetus if you are pregnant.

World

social order which will provide employment, decent housing, living wages and a free and accessible health service.

South Africa has one of the most fragmented health services in the world. In the urban areas this has resulted in confusion regarding responsibility, competition between different levels for resources, inadequate co-ordination and the duplication of services.

The State's drive towards the increasing privatisation of its services has severe implications for the health of the people.

The recent increases in hospital and clinic fees have discouraged people from making use of public health facilities and will have disastrous effects on the health of the unemployed, the disabled, pensioners and the chronically ill.

SAHWCO sees this as the State abrogating its responsibility in providing health care for all its people.

This has led to the establishment of a number of community-based organisations which provide essential primary health care for the disadvantaged.

SAHWCO, as a firm supporter of the United Nations' Charter of Human Rights and the Declaration of Tokyo, fully endorses International Health Day.

● The National Medical and Dental Association (Namda) said International Health Day presented challenges to the government and the community.

The challenge to the government is to make health care accessible to the majority of the community. The challenge to the community is to put health on the political agenda alongside education, housing, rents and forced removals.

Namda called for the immediate desegregation of all hospitals and the intergration of both preventative and curative health services under unified non-racial authorities.

"Ultimately people will only be assured of decent health care once they have the political power to influence the allocation of resources," the association said.

Do's and don'ts for a good life

FOR CHILDREN:
☐ Learn about yourself – understand how your body is changing and growing.
☐ Keep your body clean – you are responsible. Bathe often and clean your teeth.
☐ Eat well – your body must grow. Enjoy fruit and vegetables.
☐ Play with care – learn to be careful at school, in play, on the roads.
☐ Make friends – be a good friend, make young and old friends.
☐ Keep your world clean – make your house, your street, your neighbourhood, good places to live.
☐ Learn to say no if you are asked to do things that make you feel uncomfortable. Say no to drugs.
☐ Medicine – don't play with medicines. Take only what you are given by your parents or doctor.
☐ Immunisation – serious childhood diseases are avoided thanks to vaccines.
☐ If you feel ill – tell your parents or consult a health worker, and learn to care for others who are sick.

FOR YOUNG PEOPLE:
☐ Eat right – regular and well-balanced meals contribute to good appearance and healthy adulthood.
☐ Drink right – clean water and fruit juice are good for health. Avoid alcohol.
☐ Smoking – if you want to be healthy and attractive don't smoke.
☐ Find time to relax – games, music, art, reading and talking to others, helps you relax and make you a more interesting person.
☐ Be positive – think positively and constructively.
☐ Know your limits – look before you leap... a moment's inattention could ruin your life.
☐ Responsible sexuality – understand your own sexuality and be responsible.
☐ Sport is good for you – it will make you look and feel better.
☐ Drugs – drugs are a dead-end trip.
☐ Drink right – you need at least two litres of liquid a day – mostly water. Alcohol can be especially harmful to you and the foetus if you are pregnant.
☐ Smoke – for your own health (particularly if you are using oral contraception), that of your family, that of your unborn child if you are pregnant – DON'T SMOKE.
☐ Walk – as often as possible, particularly after menopause, when it helps to strengthen your bones.
☐ Set aside time for yourself – cultivate interests outside your daily routine.
☐ Be constructive – being constructive means loving and caring while sharing burdens.
☐ Take care – practise family planning for your own health and that of your children.
☐ Sex – enjoy your sexuality. Try to have one stable sexual relationship with a faithful partner, otherwise make sure he uses a condom.
☐ Drugs – don't use illegal drugs or abuse prescription drugs.

FOR THE ELDERLY
☐ Eat right – eat smaller portions – perhaps more often – of well-balanced nutritious low-fat foods.
☐ Drink right – drink plenty of liquid, but go easy on beer, wine and spirits.
☐ Smoking – It's never too late to stop.
☐ Walk – walking is the best way to keep fit and alert.
☐ Make the most of recreation – keep in touch with family, friends and neighbours.
☐ Be positive – being positive and cheerful makes people want to be with you.
☐ Take care – your life and the lives of others depends on a clear head and a clear vision.
☐ Sex – there is no age limit to sexuality or sex.
☐ Sport is good for you – sports, provided they are not too strenuous, are beneficial to health.
☐ Drugs – avoid the abuse of anti-depressants and sleeping pills.

FOR WOMEN
☐ Eat right – nutrition is particularly important during pregnancy and breast-feeding.

FOR MEN
☐ Eat right – know what you eat and when to stop.
☐ Drink right – you need at least two litres of liquid a day – mostly water. Alcohol and driving don't mix.
☐ Smoke – smoking or chewing tobacco is unhealthy and unattractive.
☐ Find time for recreation – find time to enjoy your family life.
☐ Be positive – an open mind and a positive attitude are more effective than confrontation.
☐ Take care – safety first whether you are driving, working or at home.
☐ Sex – have one partner, otherwise use a condom.
☐ Sport – sport is good for your physical health.
☐ Drugs – don't use illegal drugs.

World health marked by UN

THE World Health Organisation (WHO) has given a number of pointers towards better health to commemorate World Health Day. These are:

NUTRITION: "Good nutrition lays the foundation for good health," WHO Director-General, Hiroshi Nakajima, recently said.

Nutritional status itself depends on good health and more: it is the result of a complex interaction between overall status, diet, and the physical, social and economic environment.

ALCOHOL: Alcohol is a socially and legally accepted drug, which has been with us in one form or another from time immemorial.

The ancient Hindu medical treatise *Ayurveda* provides a detailed account of uses and abuses of alcoholic beverages.

EXERCISE: When confined to bed for any length of time, muscles become atrophied, blood circulation is slowed down, resistance to infection is lowered and bone consistency diminishes.

There may also be insomnia, slower heart rate and constipation.

RELAXATION: There are few people who have not experienced at least one period of depression. Nature has its own way of dealing with the shock of bereavement, the collapse of a marriage, natural catastrophes or the horrors of war. Again, almost everybody finds that time is the great healer and that normality returns to the troubled spirit.

DRUGS: Both narcotic and psychotropic drugs are being misued. According to figures reported to the United Nations the size of the drug epidemic is:

● Narcotics: 4,8-million cocaine abusers, 1,7-million opium users and 750 000 heroin abusers.
● Psychotropics: 3,4-million abusers of barbiturates and tranquillisers as well as 2,3-million abusers of amphetamines.

YOUR HEALTH: Over the last 100 years medicine and science have made great strides. They have contributed to improving the overall health status of most people.

On the other hand, with the exception of vaccinations, we have to recognise that in industrialised countries medical interventions have not been the major catalysts for bringing about these improvements.

The changes have resulted from social measures and individual care.

'An integrated economy vital for SA'

THE structural changes necessary for full development must include substantial shifts in distribution of income in the direction of low income households, more labour intensive methods of production, wage rates and inflation, a greater decentralisation of control of production, employment and business generally, argued Theo Rudman, director of the Self-Employment Institute, in a speech to the Cape Town Press Club recently.

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The much larger Third World population contributed to and benefited from this process of growth to a limited extent due to the social framework of separate economic development created

As pointed out in the recently published Second Carnegie Inquiry into Poverty and Development in Southern Africa, the problem of underdevelopment facing South Africa is both immense and urgent.

Here are excerpts from a recent speech on the issue by Self-Employment Institute director THEO RUDMAN:

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This led to a high propensity to import consumer goods or to apply savings to investments abroad wherever possible.

Add to these purely socio-economic considerations the high tax rate implications of a socio-political system which requires increasing government consumption resources without much growth in the resource and tax base.

The result of such circumstances, if they were real, could well be domestic stagnation of economic activity.

To integrate our Third World economy with our First World economy is, I believe, vital if South Africa is to prosper and develop.

This integration could provide a "shot in the arm" to our ailing formal economy in the absence of foreign investment.

In my view, the most effective way to integrate the two economies is through the centre satellite system.

Foreign organisations should have the opportunity to support, develop and

The unrestricted integration of the First and Third World economies out of basic economics would quickly free this huge hidden wealth.

It would turn our black population from what many people see as a huge liability into an enormous asset.

By freeing the informal sector and allowing business to be operated more easily and economically South Africa would really take off and be the economic giant it has so far failed to be.

By freeing small formal businesses and the informal sector, and removing monopolistic protection from big companies through control or marketing boards, big business would be forced to be as productive and efficient as possible.

They would see that it would be vital to their survival to use small enterprises as an important part of their business activity.

This would enable big business to reduce its capital and running costs.

'SA health services limited'

PRETORIA — SA could never afford First World health services, National Health Director-General C F Slabber said here yesterday.

Opening the new Council on Nursing, he said SA ranked 21st in the world league table of total GNP. However, when population was taken into account, SA achieved only 50th position in the world GNP per capita table.

According to the World Health Organisation, SA, together with 13 other countries, such as Algeria and Portugal, fell within the lowest range of middle-income countries.

"The obvious conclusion is funds within SA are limited and will remain limited for the foreseeable future," Slabber said.

85 GERALD REILLY

He said it had to be accepted SA was not a First World country. It was a Third World country with a small First World component.

Slabber said there had been a steady decline in the number of student nurses since 1984. There were 13 360 student nurses on the council's register in 1984, 11 818 in 1986, 10 435 in 1988, and 9 955 this year. BDay 4/4/89.

He added there was a double problem — a fall in the actual number of students and a poor distribution. The long-term prospects were bleak and, with an ageing population and a declining birth rate, the situation could only get worse.

Prevention the only cure – experts

Star 8/4/87

PREVENTIVE health measures would do much to bring down South Africa's infant mortality rate and promote a stronger economy, the Department of National Health and Population Development has pointed out.

In its World Health Day message yesterday, the department said South Africa could not afford to let its children or the economically active die from preventable diseases. It was time for each and every individual to learn preventive health measures.

The World Health Organisation (WHO) has encouraged health authorities to promote health rather than discuss disease. "Every man, woman and child should be in a position to choose a healthy way of life," said Dr Hiroshi Nakajima, the director-general of the WHO.

He said in order for preventive health measures to be effective, each person had to be aware of how to promote a better way of life. It was for this reason that the WHO had chosen "Let's talk health" as this year's World Health Day theme.

To promote healthier lifestyles, the department has, in conjunction with other organisations, arranged a number of activities focusing on prevention rather than cure.

These include an exhibition at the Rand Afrikaans University where blood pressure and cholesterol levels will be measured, exhibitions at public libraries throughout the country and lectures at Potchefstroom University on low blood pressure and correct eating.

See Page 10.

MEDICAL REPORTER

World Health Day call for hospitals to be desegregated

JANET HEARD

APARTHEID came under attack today (International World Health Day) as one of the root causes of ill-health for most South Africans.

One way to tackle the problem was to desegregate hospitals immediately, it was said.

The National Medical and Dental Association (Namda) publicity secretary, Dr Max Price, said today's international focus on health presented a challenge to the State to make health acceptable and affordable to most South Africans.

This should not stop people from demanding the authorities improve the health services immediately.

"The rural areas, peri-urban informal settlements, and farmworkers have almost no access to health care. In urban areas, where access is better, the overcrowding and high fees often deter people from using the services.

"Namda calls for the immediate desegregation of all hospitals. We want to see the integration of preventive and curative services under unified, regional and non-raical authorities."

Namda called for the provision of adequate services in the informal settlements.

"Ultimately people will only be assured of decent health care once they have the political power of the vote to influence the allocation of resources."

The challenge to communities was to put health on to the political agenda alongside housing, rent and removals.

Louw warns medics on politics

Staff Reporter

ANC supporters in the medical professions were mixing their "extremist politics" with medical principles, Administrator of the Cape Mr Gene Louw said this week.

Speaking at a congress in the city on "Labour Relations in Health Services", Mr Louw warned that health services were "by no means excluded from the intensity of the revolutionary onslaught in South Africa today".

About 300 delegates attended the two-day congress which was organised by the Department of Health Services and Welfare, Administration, House of Assembly South-West Cape Region.

"We regrettably learnt of the fact that the ANC members of the medical profession organise under the banner of 'Natural Health System' and 'Health for All', and are thus launching a strong medico-political health strategy in which extremist politics are inextricably bound with medical principles," he said.

While the health services could expect increased political attacks, several "so-called health organisations" whose main purpose was "purely political", would appear occasionally, Mr Louw said.

The National Medical and Dental Association (Namda) had, for example, subscribed to an advertisement commemorating "75 years of the ANC" and the ANC had, in turn, referred to Namda as a "front organisation", he said.

Reacting to Mr Louw's statements last night, a Namda spokesman said apartheid, besides "predetermining" an individual's political, economic and social status, had a "profound effect" on their health status.

It could not be denied that blacks in SA suffered from diseases of poverty such as TB, kwashiorkor, malnutrition, gastro-enteritis etc, whereas whites generally suffered from diseases of affluence.

"Health for All", the spokesman said, was not a "radical or jargonised concept", but a strategy initiated by the World Health Organisation and one to which the majority of the countries in the world subscribed.

Mr Louw appealed to health practitioners to elevate the health profession "far above politics and to practise it with independent and unsullied professionalism".

SA medicine under siege

Own Correspondent

CAPE TOWN — The former president of the SA Medical Research Council yesterday warned that the high standard of medicine and the country's ability to make significant international contributions were under threat.

Addressing the congress of the Medical Association of SA in Maritzburg, Professor Andries Brink said modernisation was lagging behind and had resulted in disenchantment among medical academics.

The Administrator of the Cape, Mr Gene Louw, said health services were under threat from "the revolutionary onslaught".

He said ANC members of the medical profession were organising under the banner of a national health system offering "health for all". They were launching a strong medico-political health strategy in which extremist politics were entangled with medical principles".

Doctors in wrangle over racism charge

Star 13/4/89

MARITZBURG — A row erupted yesterday at the South African Medical Association "indaba", with accusations that the Medical Association of South Africa (MASA) was racialistic.

Professor T Jenkins, head of the Department of Human Genetics at the South African Institute of Medical Research, said he believed that as a medical association, MASA had a clear duty to condemn racialistic practices by the medical profession.

Professor Jenkins was dealing with the

(85) WMAIL 14-20/4/89.

Namda robbed by careless thieves

THE national headquarters of the National Medical and Dental Association (Namda) were burgled on Sunday night, but nothing appears to have been stolen.

Namda officials said the burglars forced one door and appeared to have had a key for a second.

In the same suite is a special clinic for detainees, and offices of other Namda projects, but there was no evidence of theft.

The national executive committee of Namda described the incident as "extremely suspicious.

"The manner in which the break in was carried out suggests that the motivation could only be political as nothing was stolen. We believe that it was carried out to obtain information, to plant a bugging device or to intimidate Namda."

The executive also said the burglary was particularly suspicious in the light of last month's incident at the Durban offices of Kagiso Trust. A trustee claimed he surprised two security policemen conducting a torchlight search of the offices. Police have denied the claim.

BUDGET VOTE: NATIONAL HEALTH AND POPULATION DEVELOPMENT

PRESENTATION ACCORDING TO STANDARD ITEMS

Items	1989/90	1988/89
	R'000	R'000
Personnel expenditure	109 640	121 716
Administrative expenditure	17 028	16 847
Stores and livestock	34 221	31 566
Equipment	11 485	8 645
Land and buildings	—	—
Professional and special services	25 573	22 332
Transfer payments	378 084	353 966
Miscellaneous expenditure	2 104 717	1 768 004
Amount to be voted	2 680 748	2 323 076
Amount forming a direct charge on the State Revenue Fund in terms of Sec 13 of the RSA Constitution Act, 1983 Pensions to ex-State Presidents or their widows	370	300
Total estimated expenditure	2 681 118	2 323 376

Departmental and miscellaneous receipts: R4 140 000.

1989/90: Officials earning R80 000 and more — 203
1988/89: Officials earning R59 200 and more — 51

Source: Estimates of Expenditure.

Should doctors be free to treat whom they please?

Medical circles debate race and ethics issue

Star 22/4/89

(85)

THE CHALLENGE by two Johannesburg doctors that it should be clearly stated that it is unethical for a practitioner to refuse to render service to people on the basis of their skin colour has stirred widespread debate in medical circles.

The latest response came from the South African Medical and Dental Council (SAMDC), which said it would be "entirely unbefitting" for a practitioner not to render services to any particular patient on racial grounds.

However, SAMDC's policy, that a practitioner was free to decide to whom he wants to render a service to or not, remains unchanged.

Speaking on behalf of the SAMDC, the registrar, Mr Nico Prinsloo, said: "It would be entirely impractical for a practitioner to see all patients who wish to see him or to be available continuously."

He said, however, that practitioners were obliged to render assistance to black patients in emergencies under all circumstances. Practitioners who refused to serve black patients would have to justify their action in the event of unnecessary suffering or death.

The SAMDC's response

JANET HEARD

came in the wake of a letter in a recent issue of the South African Medical Journal written by Professor Trefor Jenkins, head of human genetics at the South African Institute of Medical Research, and Dr Yosuf Veriava of the medicine department at Coronation Hospital and Wits University. The letter called for the Medical Association of South Africa (Masa) to state unequivocably that it was unprofessional for doctors to refuse to see black patients or to have separate facilities for them.

The two doctors said it would also be desirable for the SAMDC to issue guidelines which indicated that such practices were professionally unacceptable.

The Medical Association of South Africa replied that it did not discriminate between members and patients on the basis of race, colour or creed. "The Masa does not, indeed will not, accept or condone discrimination in the quality and standard of service rendered to patients, or facilities provided, on a racial basis. The same quality of medical service must be available to all patients, regardless of race or colour."

In an earlier reply this year, bediscrimination. However, it is still unclear and ambiguous and needs clarity."

He said it was the duty of the organised medical profession to give guidelines to general practitioners who may be confused as to whether they could refuse patients on the grounds of colour.

"Medical practioners have the right to refuse seeing patients on certain grounds, such as if the disease is outside the doctor's sphere of expertise, or if there is an intractable personality incompatibility. However, in South Africa, this right has made it possible for doctors to refuse treating patients on the basis of the patient's skin colour. This is unethical and unprofessional," Dr Jenkins said.

Community service for young doctors 'may backfire'

PAT DEVEREAUX

THE National Medical and Dental Association yesterday said a plan to force graduating doctors to do community service before being allowed to register with the Medical and Dental Council could backfire.

Namda was reacting to the SAMDC's adoption of a resolution this week which intends to introduce a new measure — involving student doctors doing community service in rural areas — in an attempt to stem the flow of doctors emigrating from South Africa.

At present all graduate doctors must register with the 20 000-member council before they can practise.

The new resolution adopted by the council means that before registration with the council a graduating doctor would have to complete a term of community service, according to the SAMDC registrar, Mr N Prinsloo. The length and conditions of the community service must still be discussed.

The SAMDC, at its three-day meeting this week, said it believed that community service prior to registration would at least slow a high emigration rate among doctors who leave because of the racial tension and international isolation associated with apartheid or because they seek higher salaries elsewhere.

However, Mr Prinsloo added: "This form of community service should not be seen as linked to military service, but as similar to a form of internship."

Reacting to the decision, publicity secretary for Namda, Dr Max Price said: "The SAMDC are primarily concerned with reducing the emigration of young doctors. But what they are proposing will simply defer emigration for two years and may even increase emigration — since graduates may see two years of compulsory service as a diversion from their career developments."

Mentioning recent research conducted by the Universities of Cape Town and the Witwatersrand, Dr Price said: "The main reason for emigration is compulsory conscription of white male doctors."

Research statistics given at this week's SAMDC three-day meeting showed South Africa lost 34 doctors in 1986, 25 in 1987 and nine in the first half of 1988. By last May 66 percent of medical graduates from the University of the Witwatersrand had left or were thinking of doing so.

Frustrations

Dr Price said Namda called on the Government to offer conscripts the alternative of community service instead of military service. He said this would indeed have the effect of reducing emigration and increasing the flow of doctors to rural areas.

"We believe there is a critical shortage of medical care in rural and impoverished peri-urban communities, but the frustrations of working in rural areas are the most important reasons for the lack of staff there.

"The causes of this include the more fundamental issue of apartheid which allocates too few resources to the majority of the population where finances are needed most. This is why these areas are understaffed. Other factors include the urban and specialist bias in the training of medical students and in their selection," he added.

The idea of allowing doctors to do alternative service instead of military service was apparently first raised with the SADF in July by the Academy of Family Practice which asked the SADF to credit newly qualified doctors with two years' national service if they volunteered to work in rural areas for that period.

Further support for the idea, of doctors doing alternative community service instead of military service, was expressed after the jailing of conscientious objector, Dr Ivan Toms, to 21 months' imprisonment last year for refusing to serve in the SADF. In last year's October and December issues of the *South African Medical Journal* over 50 professionals concerned with health care called upon decision-makers to find alternative options to military service.

Change will not affect patients — Badenhorst

THE reclassification of the J G Strijdom hospital as a white own affairs hospital would have no effect on the admission of new and existing black patients, House of Assembly Own Affairs Health Minister Piet Badenhorst said.

The only significance of the reclassification was that the hospital's funds would now come from the Health Services and Welfare Department in the House of Assembly and not from the Transvaal Provincial Administration, he said.

The Medical Association of SA's (Masa) federal council chairman Dr B Mandell said yesterday staff resignations at the hospital, as a result of the reclassification, were an undesirable result of the continued fragmentation of SA's health services.

ADELE BALETA and DIANNA GAMES

Mandell said Masa had made several representations to government about such fragmentation.

He added Masa urged the doctors who had resigned, and the authorities, not to act rashly and to try to reach agreement on the issue.

Masa has requested an interview with the authorities concerned to assist in solving the problem, he said.

Badenhorst said discussions with Wits University departmental heads would be held on May 17 to plan a programme of action to ensure continuation of service to patients.

He said there would be no change to existing hospital policies in regard to staffing, appointment of academic staff, patient population and other hospital activities.

Wits' medical school dean Prof Clive Rosendorff said the university had made its position clear that, by government's own definition, the change to own affairs stripped the hospital of its position as a teaching hospital.

Raid on Namda offices

THE offices of the National Medical and Dental Association in Durban were raided by security police this week.

According to a statement by the national executive committee of Namda, five security policemen spent three hours searching the offices in the Lancet Medical Centre in Lorne Street on Tuesday.

Seized

"They confiscated computer discs, documents, books and a telephone directory. They visited the office again on Wednesday and additional material was taken."

According to the statement, material taken the day before was returned.

"Yesterday's raid was the third of this nature and occurred just three days before the annual Namda conference which opens on Friday," the statement said.

"Our head office in Durban was also raided by security police after the conference in 1986. Minutes, books and resolutions were confiscated," he said.

SP raids Namda HQ

MEMBERS of the Security Police raided the Durban head office of Namda (National Medical and Dental Association), three days before the start of its annual conference which opened in Johannesburg last night.

According to a statement from Namda's national executive, five security policemen spent three hours searching the offices on Tuesday and confiscated computer disks, documents, books and a phone directory.

A month ago, the head office was forcibly entered by "unknown people who seemingly did not take anything".

Where a doctor-patient relation-

of patients to their beds.

Govt turnabout on medical equipment deal

Import surcharges back

GOVERNMENT has re-introduced an import surcharge on most items of medical equipment, which had the 20% surcharge removed at the end of March after representations to government by the medical equipment industry.

The items, which include several items of dental equipment, massage and X-ray apparatus, radiography and electro diagnostic equipment, infra red and ultra violet apparatus, have now had a 15% surcharge re-imposed on them.

The surcharge has been backdated to August 15.

Several importers of such equipment are already making arrangements to go back to government on the issue.

Leonard Swanson of Rand Medical Supplies, who initiated the original

DIANNA GAMES

protest to government on the old surcharges, said the move had put them back to where they were before.

"Hospitals are already short of millions of rands and the cost of medical services is already very high. This is certainly not going to help," he said.

Barney Hurwitz, chairman of SA's largest private hospital group, Clinic Holdings, said they were very disturbed at the re-imposition of the surcharges as they would have an inflationary effect on health costs.

He said with the already high health costs, the extra 15% would reduce investment in medical equipment by many bodies, including provincial hospitals. "As a result of this, the standard of medicine must drop," he said.

One supplier, who did not wish to be named, said the real problem lay in the 20% surcharge on surgical disposables which could add up to R30m on health bills in one year.

The market was primarily import-oriented but the very small local production market did not need the protection of a surcharge as the exchange rate meant local products had a guaranteed market.

In his company alone, out of 140 products, only 10 were locally made.

"If this is a mistake, it is an abysmal one. If it's not, the whole Board of Trade and Industry should resign," he said.

Comment from the board on the re-imposition was not forthcoming at the time of going to press.

Threat to sue health union

By MOJALEFA MOSEKI

THE Balfour Town Council has threatened legal action against the South African Health Workers Congress which revealed that water supplied to the black township of Siyathemba was contaminated with human faeces.

The telex to SAHWCO was sent by Balfour council secretary Mr J T Potgieter who demanded information on when the water sample was taken, where and at what time of day and the method in which it was collected before being tested in a medical laboratory.

The council said it was considering legal action "within seven days" if no response was received from Sahwco.

Sowetan 19/5/87

A spokesman for Sahwco yesterday said they did furnish the council with the required information despite the fact that Sahwco "strongly objected" to the threats by the council.

He said the organisation welcomed legal action by the council as it was give "us a chance to expose the numerous violations of the Health Act and basic human rights" by the Balfour council.

The spokesman said since the report was released the council had fitted pipes and taps from which residents could draw water. It has also undertaken to install a pipeline to pump 600 kl a day into Siyathemba to increase the water supply. The arrangement ensured that the water was not contaminated.

Stink over polluted Siyathemba boreholes

Health workers stand firm

Siyathemba citizens block their noses to the stench at the collection point for water at the local borehole.

Pic: ANDRIES MCINEKA

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radical and moderate factions.

The ANC leader said his fears were based on an an increased number of public statements by Pretoria officials recently that there are divisions within the ANC between members of the governing National Executive Committee who favour an escalation of bombing attacks on "soft" civilian targets in South Africa and those who favour a negotiated settelement.

The ANC had recently uncovered pamphlets published in London under the name of the "ANC Support Group", which was unknown to the ANC. These pamphlets sought to promote divisions in the ANC by declaring that the movement's advocates of a negotiated solution were undermining the efforts of the military wing, Umkhonto weSizwe.

— Washington Post

despite council's legal threats

By STAN MHLONGO

THE SA Health Workers Congress this week refused to give in to threats of legal action by the Siyathemba Town Council for alleging that a borehole in the area was contaminated with faeces.

Photographs taken by *City Press* following on-the-spot investigations into the water situation in Siyathemba confirmed Sahwco's allegation that residents get water under "inhuman conditions".

The following findings were found in Siyathemba this week:

■ In Wagplek, a squatter area in Siyathemba, residents queue for water at a tap with faeces on the ground around it – confirming Sahwco's allegation that sanitation trucks removing raw sewage are washed with water used for daily consumption by residents.

■ To avoid long queues for water, other residents use water from natural "springs" which have cropped up as a result of the rains that have fallen in the area recently.

A Johannesburg lawyer, A Samons, acting on behalf of Sahwco, confirmed receiving a letter from the council threatening legal action.

"The council also demanded answers to questions concerning the contaminated borehole and pointed out that should we fail to respond within seven days, they would consider taking legal action against Sahwco," said Samons.

Sahwco was asked to provide answers to the following questions:

■ How was the water sample extracted from the borehole?

■ On what dates were the samples of the contaminated water at the borehole taken? and

■ At what time and at which borehole?

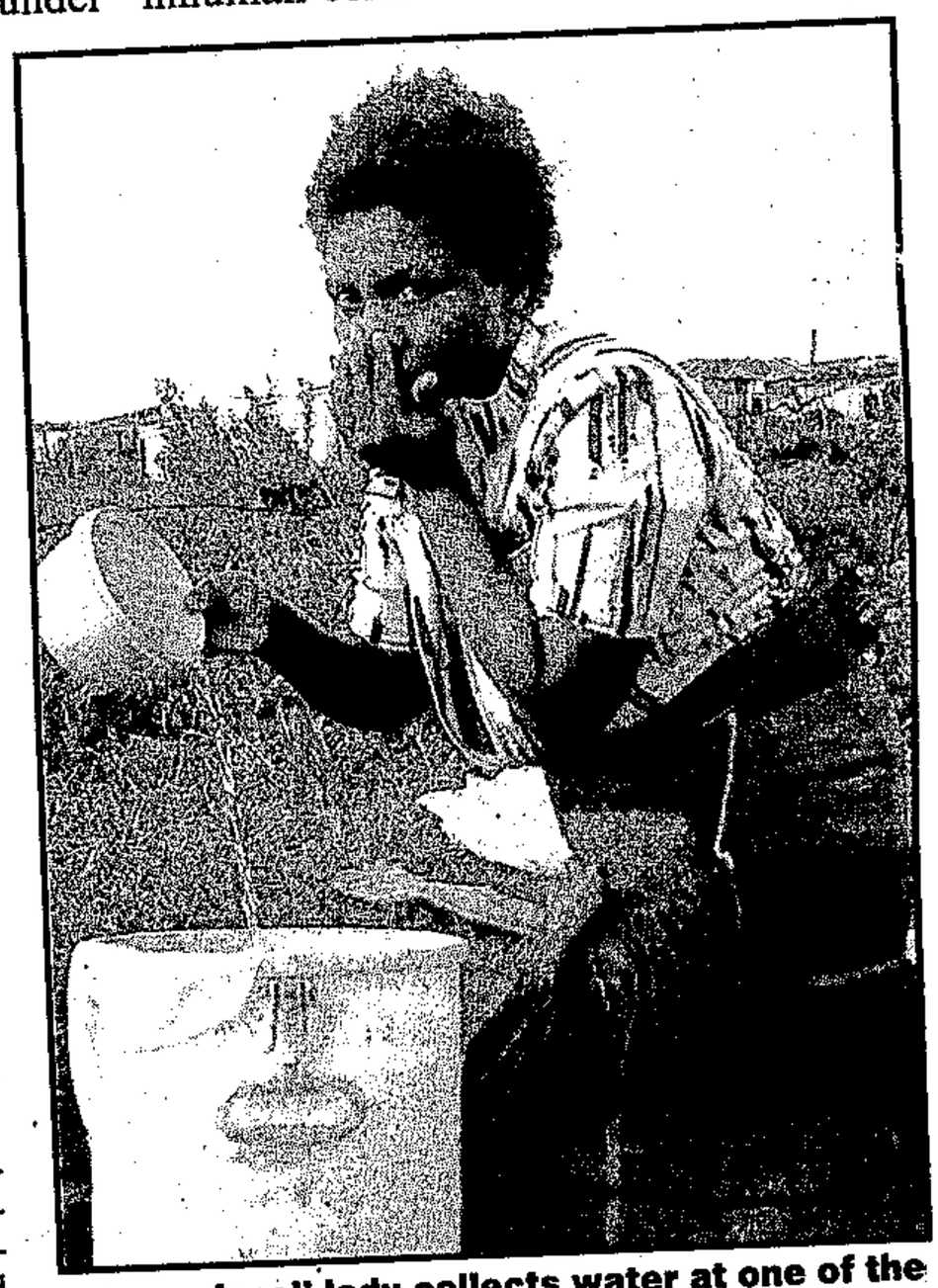
The lawyer said Sahwco had responded by giving the relevant answers to the council.

He said this did not mean Sahwco had been intimidated by the threats of legal action, as the organisation stood *by everything it had said about the contamination at the borehole.*

The Conservative Party-controlled Balfour City Council has stressed that it has nothing to do with the latest "confrontation" between the Siyathemba Council and Sahwco over the borehole.

Balfour council town clerk, M Joubert, said the council was supplying water to Siyathemba residents through taps and had nothing to do with boreholes.

This was confirmed by Siyathemba mayor, Dan Mapohoshe, who last week reacted to the contaminated water allegations by saying that residents no longer received water from boreholes – and only did so during the time when there was a water crisis.



A "nameless" lady collects water at one of the smelly new springs in the area.

Mapohoshe said he was not aware of the letter written to Sahwco by his council.

The Siyathemba town clerk, JP Potgieter, replied: "I am not prepared to comment," to a question on the threatening letter.

According to a report by Sahwco the contaminated water samples were taken on April 20 and tested by the SA Institute for Medical Research the following day.

Sahwco also claims that it found that *there are between 1 500 and 2 000* times more contaminating bacteria in the Siyathemba water supply than in the normal urban water supply.

One resident in the squatter area, Eveline Mofokeng, said: "There is nothing we can do. We have to drink the water or die of thirst."

A medical practictioner in Balfour said there was an increase in scabies – a disease caused by a lack of water. The doctor also said the number of diarrhoeal diseases had increased dramatically.

Research output further privatised

DIANNA GAMES

THE Medical Research Council (MRC) further privatised its research output in the last financial year, partly with a view to investigating possible new avenues of import replacement for medical electronic equipment, MRC president Philip van Heerden said yesterday.

He said in his annual report the MRC had registered two companies — Medical Technologies Investments and Medical Technologies Development (Medtech).

Although the MRC held 100% of the shares in the companies, it was envisaged at least 75% of the share capital would be taken up by the private sector.

Medtech, together with other interested parties, would use information from a market survey on medical electronic equipment to investigate possible new avenues of import replacement with locally made equipment.

The MRC operating account showed a surplus of R10,6m, which was transferred to the Accumulated Fund. This showed a 23,6% increase over the previous year.

The bulk of MRC funding — R30,9m in the last financial year — came from parliamentary grants. Of that, R18,4m was paid out for running costs, R11,4m for research grants and bursaries and R1m for contract research. It also spent R17m on its own research programmes and R11,9m on salaries, wages and allowances.

The MRC last year opened a new Research Institute for Environmental Diseases, a hitherto neglected field, and would be looking at diseases resulting from water, air and food pollution, among other things.

Extensive

Van Heerden said in spite of threatened isolation and boycotts, international co-operation was still satisfactory and researchers still had access to the best centres in the US and Europe. But attendance at international congresses had been more difficult due to visa problems for countries such as Canada and Australia.

SA was the only country in the subcontinent with its own extensive infrastructure for doing advanced medical research and it was essential standards were maintained.

Adres van eiendom	*Ligging van eiendom*
Sesde Laan 144 en 144a, Bezuidenhoutvallei, Johannesburg	Erf 252, Johannesburg te Bezuidenhoutsvallei.
Carterweg 30 en 32, Forest Hill, Johannesburg	Erf 552, Johannesburg te Forest Hill.
Woonstelle 1–4, Observatoryhof, Hunterstraat 141, Bellevue-Oos, Johannesburg	Erf 117, Johannesburg te Bellevue-Oos.
Woonstelle 5–12 en 14–21, Lawson Mansions, hoek van Loveday- en Breestraat, Johannesburg	Erf 1240, Johannesburg.
Woonstelle 1–4, Armandhof, Raymondstraat 31, Bellevue, Johannesburg	Erf 239, Johannesburg te Bellevue.
Marsstraat 6 en 6a, Malvern, Johannesburg	Erwe 116 en 118, Johannesburg te Malvern.
Woonstelle 401–412, 501–514, 601–610, 701–710, 801–810, 901–910, 1001–1010, en 1101–1108, Africa House, hoek van Rissik- en Kerkstraat, Johannesburg	Erwe 1115, 1116, 1117 en 1123, Johannesburg.
Banketstraat 83 en 83a, Hillbrow, Johannesburg	Erwe 3254 en 3155, Johannesburg te Hillbrow.
Atholstraat 222, Highlands-Noord, Johannesburg	Erf 1923, Johannesburg te Highlands-Noord.
Woonstelle 1–18, Elfredahof, Sherwellstraat 59, Doornfontein, Johannesburg	Erwe 165, 166, 167, 218, 219 en 220, Johannesburg te Doornfontein.
Woonstelle 11, 12, 21–26, 31–36, 41–46, 51–56, 61–66, 71–76, 81–86, 91–96 en 101–104, Dorchester Mansions, Rissikstraat 73, Johannesburg	Erf 4571, Johannesburg.
Woonstelle 1–12 en 14–28, Clive Mansions, Eastlaan 27, Hillbrow, Johannesburg	Erf 4026, Johannesburg te Hillbrow.
Woonstelle 1–4 en een woning, Ascothof, Ascotweg 31 en 33, Bertrams, Johannesburg	Erf 180, Johannesburg te Bertrams.
Woonstelle 31–35, 41–45, 51–55, 61–65 en 71–75, Twinbro House, hoek van Noord- en Wandererstraat, Johannesburg	Erwe 1810 en 1811, Johannesburg.
Lilystraat 50 en 50a, Rosettenville, Johannesburg	Erf 368, Johannesburg te Rosettenville.
Araratstraat 96 en 96a, Westdene, Johannesburg	Erf 1013, Johannesburg te Westdene.
Anzacstraat 94, Newlands, Johannesburg	Erf 2626, Johannesburg te Newlands.
St Albanslaan 32, Mayfair-Wes, Johannesburg	Erf 132, Johannesburg te Mayfair-Wes.
Sesde Straat 46, Parkhurst, Johannesburg	Erf 1954, Johannesburg te Parkhurst.
Sesde Straat 29 en 29a, Vrededorp, Johannesburg	Erf 159, Johannesburg te Vrededorp.
Wesstraat 36 en 36a, Mayfair, Johannesburg	Erf 2040, Johannesburg te Mayfair.
Gardenstraat 17 en 17a, Rosettenville, Johannesburg	Erf 360, Johannesburg te Rosettenville.
Sesde Laan 17, 17a en 17b, Bezuidenhoutsvallei, Johannesburg	Erf 25, Johannesburg te Bezuidenhoutsvallei.
Woonstelle 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42, 44, 46 en 48, Houghton View Heights, Kenmereweg 50, Yeoville, Johannesburg	Erwe 930 en 931, Johannesburg te Yeoville.
Mabelstraat 79, Rosettenville, Johannesburg	Erf 814, Johannesburg te Rosettenville.
Ferreirastraat 21 en 23, Turf Club, Johannesburg	Erf 9, Johannesburg te Turf Club.
Woonstelle 1–12, 12a en 14–42, Manleyhof, Goldreichstraat 4, Hillbrow, Johannesburg	Erf 3898, Johannesburg te Hillbrow.
Mullerstraat 156, Bellevue-Oos, Johannesburg	Erf 126, Johannesburg te Bellevue-Oos.
Tweede Laan 18 Westdene, Johannesburg	Erf 190, Johannesburg te Westdene.
Woonstelle 1–4, Yeoville Maisonetts, Hunterstraat 64, Yeoville, Johannesburg	Erf 745, Johannesburg te Yeoville.
Woonstelle 316–319, 401–412, 501–512, 601–608, 701–708 en 801–808, Mansfield House, hoek van President- en Joubertstraat, Johannesburg	Restant van Erwe 665 en 666, Johannesburg.
Fawcusstraat 212 en 212a, Jeppe, Johannesburg	Erf 2152, Johannesburg te Jeppe.
Woonstelle 1–4, Dorsamhof, hoek van Jules- en Kingstraat, Malvern, Johannesburg	Erwe 785 en 786, Johannesburg te Malvern.
Woonstelle 1–5, 11–16 en 21–26, Stanrosehof, De Kortestraat 52, Braamfontein, Johannesburg	Erf 2812, Johannesburg te Braamfontein.
Johannestraat 9 en 9a, Troyeville, Johannesburg	Erf 651, Johannesburg te Troyeville.
Woonstelle 1–6, Bettyhof, Mullerstraat 151, Bellevue-Oos, Johannesburg	Erf 111, Johannesburg te Bellevue-Oos.
Woonstelle 1–12, 12a en 14–17, Haighhof, hoek van Haigh- en Prairiestraat, Rosettenville, Johannesburg	Erf 627, Johannesburg te Rosettenville.
Woonstelle 1–6, Stelderhof, St Georgestraat 75, Bellevue, Johannesburg	Erf 183, Johannesburg te Bellevue.

DEPARTMENT OF DEVELOPMENT AID

No. 1014 **26 May 1989**

HEALTH MATTERS — BLACK AREAS.— DECLARATION OF LOCAL AUTHORITIES

Under the powers vested in me by Section 4 (2) of Proclamation No. R. 34 of 1989, I, Gerrit van Niekerk Viljoen, Minister of Education and Development Aid, hereby declare that for the purposes of the application of the Health Act, 1977 (Act No. 63 of 1977), in Black areas that—

(a) the Director-General of the Department of National Health and Population Development shall be the local authority in respect of environmental health and dental care; and

DEPARTEMENT VAN ONTWIKKELINGSHULP

No. 1014 **26 Mei 1989**

GESONDHEIDSAANGELEENTHEDE — SWART GEBIEDE.—VERKLARING VAN PLAASLIKE BESTURE

Kragtens die bevoegdheid my verleen by artikel 4 (2) van Proklamasie No. R. 34 van 1989 verklaar ek, Gerrit van Niekerk Viljoen, Minister van Onderwys en Ontwikkelingshulp, hiermee dat die doeleindes van die toepassing van die Wet op Gesondheid, 1977 (Wet No. 63 van 1977), in Swart gebiede dat—

(a) die Direkteur-generaal van die Departement van Nasionale Gesondheid en Bevolkingsontwikkeling die plaaslike bestuur is ten opsigte van omgewingshigiëne en tandheelkunde; en

Medical links 'survive boycotts'

Star 29/5/89

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By Toni Younghusband,
Medical Reporter

Links between South Africa's medical researchers and their overseas counterparts remained satisfactory despite threatened isolation and boycotts, the president of the South African Medical Research Council (MRC), Dr Philip van Heerden, said last week.

Addressing a press conference on the MRC's annual report for 1988, Dr van Heerden said South African medical researchers were highly regarded by their peers overseas and young developing researchers still had access to the best centres in the United States and in Europe. South Africa also retained good ties with Israel, Taiwan and Chile.

However, South Africans were finding it increasingly difficult to attend conferences overseas because of the problems in obtaining visas. Dr van Heerden said it was also important that South Africans realised they could not isolate themselves from the rest of Africa.

He said sickness knew no boundaries and besides the growing Aids threat, there were many other diseases in Africa such as malaria, infectious diseases, liver cancer and oesophageal cancer crying out for solutions.

"Collaboration in the field of medical research is of the utmost importance if we wish to improve our health and to ensure the survival of so many in this country as well as in our neighbouring countries," said Dr van Heerden.

Masa 'must state policy on human rights'

Medical Reporter

The Medical Association of South Africa (Masa) must clearly and positively state its policy on human rights, ethics and discrimination in medicine or face possible academic sanctions, the association's chairman, Dr Bernard Mandell, has said.

In his annual report, Dr Mandell said Masa's failure to take a stand on human rights and related issues might also result in expulsion from the World Medical Association and in the inevitable deterioration in medical education followed by the lowering of the standards of primary health care for the whole population.

Dr Mandell said the subject of medical ethics was assuming increasing importance within the local medical community.

"This decisive change in the pattern of medical debate indicates a more progressive and healthier trend in the approach of the professional towards ethical issues. In the past, thoughts and words have been dominantly concerned about incomes and the rights of doctors within the community, possibly ignoring the rights of the community and the human dignity of individuals," Dr Mandell said.

HUNGER STRIKES

He said the most important issues under discussion this past year had been detainees and their detention without trial, hunger strikes and fragmentation of health services.

"The association plays a vital role in the former, insisting that the physical and mental health of detainees be maintained.

"Success has been achieved but the escalation of hunger strikes within the detention system severely taxes the ethical independence of doctors treating such patients," said Dr Mandell.

Star 7/6/89

Masa speaks out against detention without trial

Pretoria Correspondent

The Medical Association of South Africa (Masa) has come out strongly against detention without trial.

The chairman of Masa's Federal Council, Dr Bernard Mandell, said yesterday the association had noted "with deep concern" the continuation of unrest and violence in the country.

Although the association was aware that detainees had the right to a second opinion where physical health was concerned, "their mental health after being detained was more disturbing".

Dr Mandell said the association would not tolerate religion, nationality, race, party politics or social standing affecting the standard of care offered by doctors to their patients.

As the health status of a population was primarily influenced by hygience, sanitation, nutrition, housing, and education, the association sought the abolition of all discriminatory measures in South Africa to ensure the end of apartheid.

SA 'can't afford first world health services'

Medical Reporter

South Africa could not afford first world health services or to spend as much as developed countries on health, the Minister of National Health and Population Development, Dr Willie van Niekerk, said today.

Speaking at a conference in Johannesburg, Dr van Niekerk said per capita expenditure on health in South Africa was R242 or 5,8 percent of the Gross National Product.

The World Health Organisation's (WHO) target for the year 2000 was 5 percent. "We have passed the target," he said.

"We must accept that South Africa is not a first world country; we are a third world country with a small first world component," Dr van Niekerk said.

He said the country had other major needs such as education and housing to consider.

According to the WHO, South Africa together with 13 other countries such as Algeria, Mexico, Panama and Portugal, fell in the lowest range of middle-income countries.

"The obvious conclusion is that funds within SA are limited and will remain limited

B/Day 12/6/89 85

World medical database for SA

DIANNA GAMES

THE SA pharmaceutical industry will soon be able to upgrade its information access on medical products from international medical information database Medi-Fax, which is to be introduced into SA later this month.

During 1989 alone, opinions, clinical trial results and research findings from 20 000 congresses around the world will be obtainable from Medi-Fax databases situated in several world capitals.

Dr Jack van Niftrik, director of Peer Opinion Medical Network, which has set it up in SA, said subscribers would have almost immediate access to a wide range of medical information, including feedback on how their own and competitive products were viewed internationally.

Opinion

Medi-Fax clinical pharmacologists overseas scrutinise and research scientific programmes of 7 000 meetings and Medi-Fax medical journalists will attend about 450 congresses to provide in-depth information from speakers.

"This means the SA product manager can keep his finger on the pulse of worldwide medical and scientific opinion on the drug, its acceptance among the world's medical profession, its efficacy in comparison with competitive agents and its latest clinical applications," a statement said.

The facility, to be conducted by facsimile and telex, will be made available to pharmaceutical product managers, the medical profession, libraries and academic and research centres.

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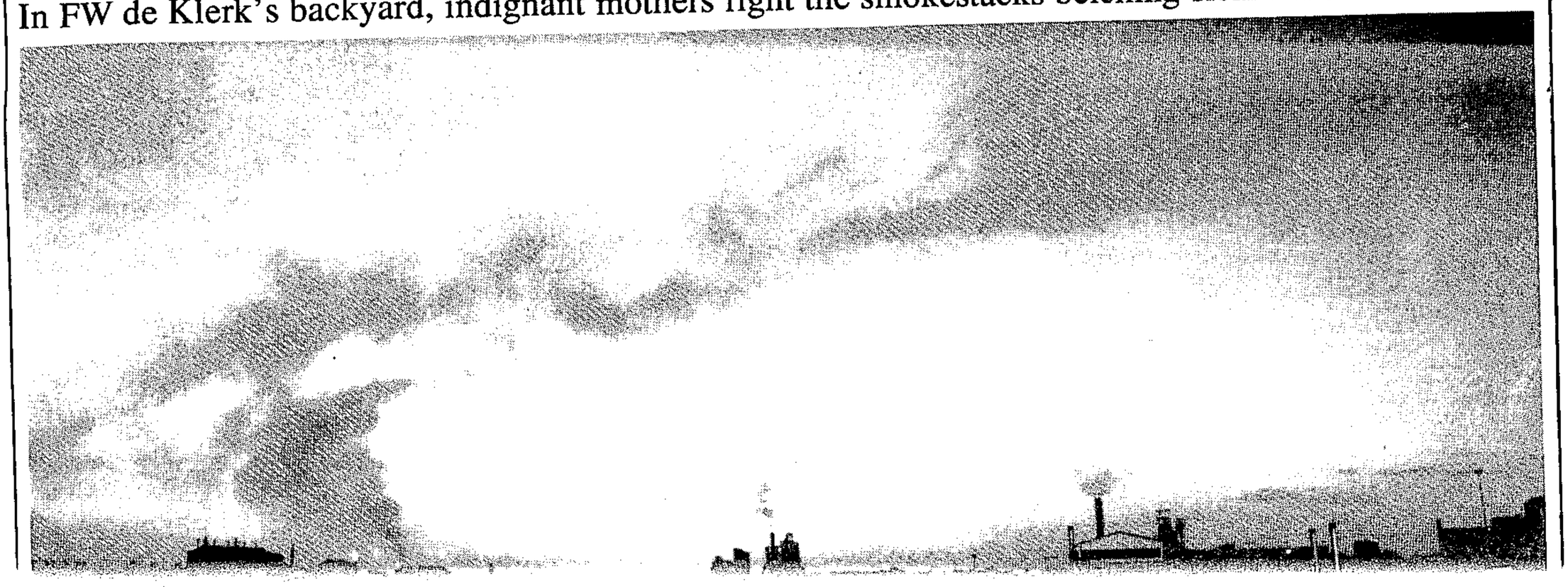
In FW de Klerk's backyard, indignant mothers fight the smokestacks belching sickness and stench ...



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A pall of industrial smoke: The Eastern Transvaal Highveld and the Vaal Triangle have some of the world's highest pollution levels — and worst respiratory problems

Under a clear blue sky, a baby sleeps. But beware...

The skies above the Vaal triangle look peaceful and blue enough on a good summer's day And industry experts say that pollution levels are down. But a group of local residents blame pollution for their children's illnesses and have launched a campaign to clean up the air. By ALISON CAMPBELL

TURN right at Iscor and keep going. In the rearview mirror the steel giant with its cloak of many vapours falls behind as one heads into the territory of tranquil smallholdings in the heart of the Vaal Triangle. Better known to locals as the Vile Triangle. The Foul Triangle.

Jenny Mufford's garden is an image of innocence. Four-year-old Helen chases ducks across the lawn while the baby sleeps in the shade. The sky is clear and blue.

"Helen's nose hasn't stopped running since she was born," says Jenny, "and her cough and sinusitis are almost as constant. As a baby she spent the winter months sleeping upright to keep her chest from closing up completely. I expect it will be the same with the new baby this winter."

The Mufford family share their recurring health problems with most people in the area. The hospital in Vereeniging hosts babies in oxygen tents for parts of the winter period when temperature inversion brings the industrially poisoned air down like a shroud.

Vaal Triangle pharmacists derive a major part of their trade from medication for tonsilitis, sinusitis, bronchitis and upper respiratory tract infections. Children on medication have difficulty in studying. Parents try to ensure that school holidays are spent away from home, and doctors openly admit that the only solution for lingering and chronic cases is to move out of the area. The locals don't need to read about air pollution; they're demanding something be done.

Jenny Mufford is the chairman of the Air Pollution Appeal Committee (Apac), a bunch of concerned mothers and others who believe the most problematic smokescreen faced by Vaal Triangle residents is the apparent disinformation which surrounds what is arguably one of the most polluted areas in the world. "We're the lunatic fringe," she explains.

"Air pollution is seen by government and industry as a public relations problem," says Jenny. "They employ experts to tell us that the sulphur levels are down, that there is no acid rain, and that mothers who fear for their kids health are neurotic. Yet steel and concrete structures all over the Vaal Triangle are crumbling under attack by acid rain and airborne corrosives."

Jenny joined the National Association for Clean Air (NACA) in 1986, and currently serves on its committee. In 1987 the *Vaal Ster* newspaper collected 10 000 signatures to a petition supporting proposals to step up legislation on pollution control. The result was a meeting between Health Minister Willie van Niekerk and residents, a meeting which Jenny describes as a fiasco.

"We were placated, patronised and provided with comparative pollution statistics from the United States which subsequently proved to be inaccurate. We got nowhere."

Inspired to go it alone, Jenny put out a questionnaire in the *Ster*, and received around 100 replies to questions like: "How many visits to the doctor have there been in the last three years?" "How many people in your family have coughs/bronchitis/sinusitis/running nose?"

People called to compare notes. For some it was the first time that they realised the problems were not exclusive to them.

The result was a paper called "Aspiration or Procrastination" which Jenny delivered at the 1988 International Conference on Residential Air Pollution hosted by NACA. She was the only individual to be involved in a private capacity.

She was joined by Carol Smith, a mother aghast at the deterioration in her childrens health after living in the area for only eight months. The association formed the nucleus of Apac. Together they approached Vereeniging's MP, FW de Klerk, in an attempt to establish the state of existing pollution monitoring in the area.

The response was again placatory, the reassurance it offered less than adequate. As in previous instances, the women were assured that the major causes of air pollution in the Vaal triangle lay not with industry but with vehicle exhaust and smoke from the fires of black residential areas.

Steps had apparently been taken to monitor the problem. Instruments had been set up at the civic centre in Vereeniging to ascertain concentrations of sulphur dioxide, nitrogen oxides and ozones in the air. Instrument calibration, recording and reporting were the responsibility of the CSIR, and plans were afoot to expand the monitoring facilities.

The graphic result of existing monitoring would appear to back De Klerks assertion that the problem is not critical. Annual and monthly levels look particularly innocuous. Until one takes into account the exact location of the monitoring sites (away from source and in some cases out of the prevailing wind), and the fact that readings are averaged out across a number of sources.

"We want monitoring on the chimney stacks, nothing less," says Jenny. "We believe the averaging system to be completely misleading."

While monitoring is the essential first step toward defining the problem, Jenny points out it is rendered ineffective without legislation to ensure that transgressors are brought to task. Apac believes that even where pollution control measures have been taken by industry, they are inadequate. Eskom records in Jenny's possession show the performance of their chosen device, the electrostatic precipitator, is rendered unreliable by being subject to intermittent overload. An additional irony lies in the fact that the low grade of South African coal inhibits the ionising process which is vital to the precipitators proper performance. So additional sulphur is injected into the coal to bring it up to scratch.

Apac does not limit its activities to nagging industry. Members believe that the lack of public awareness is as much to blame for the extent of the poison air problem as is industrial or bureaucratic indifference.

Persistent petitioning by Apac has resulted in De Klerk agreeing to introduce environmental awareness curriculae to schools in the area. A demand for epidemiological studies to be set up in the Vaal Triangle has also apparently received consideration.

The investigation will take 10 years to complete at a cost of millions to the very taxpayers who are having difficulty in breathing, says Mufford. "A similar study in the US was carried out in just six months and a lot of new industries can go up in 10 years."

Meanwhile, the horror stories flourish. Informal monitoring records a litany of illness, stench, poisoned water, indignation and frustration.

In 1987 Van Niekerk concluded one overview of the situation with the statement that in the light of his department's investigations into the situation, it should be clear to Vaal Triangle residents that "the health of the public is not affected at all ..."

Therein lies the most dangerous smokescreen on the Highveld.

A MAJOR STUDY INTO THE LINKS BETWEEN POLLUTION AND DISEASE

CONTROVERSY over foul air and the threat of acid rain in parts of South Africa has prompted a series of academic investigations into the link between atmospheric pollution and human health.

The Vaal Triangle — which, together with the Eastern Transvaal Highveld, has some of the highest levels of sulphur dioxide pollution in the world — has been singled out for special attention.

A major probe into likely links between serious respiratory diseases and air pollution in the Vaal Triangle has been launched by the Research Institute for Environmental Diseases (RIED) in Pretoria.

Head of institute Dr Bernard Fourie told the *Weekly Mail* the study, which is still in its planning stages, would investigate possible links between industrial contamination of the air and bronchitis, asthma as well as other forms of lung impairment.

"Minor ailments such as sinusitis and eye irritation, which people tend to accept as part of their day-to-day reality will also be investigated," said Fourie. While there was no evidence of higher-than-normal incidence of lung cancer in the Vaal triangle, this had not been ruled out and would form part of the study.

RIED has sent a senior researcher to Harvard University, which has one of the world's renowned centres for epidemiological studies, to study methods that could be adopted for the Vaal Triangle probe.

The Council for Scientific and Industrial Research has, simultaneously, announced a large-scale project designed to measure the extent of air pollution in the Vaal area and to identify the sources of the contamination.

Two private consultants recently said coal-burning power stations and industries on the Eastern Transvaal Highveld were pumping out 57,5 tons of sulphur dioxide a square kilometre each year, making it by far the most polluted region in the world.

Although the CSIR's figures put the level of sulphur dioxide pollution at 31 tons a year, the organisation acknowledges these levels are comparable to the most polluted spots in the world.

Dr Bruce Wells, who is co-ordinating the CSIR study in the Vaal, said that although statistics were not readily available for the region, levels of sulphur pollution were likely to be lower in the Vaal because the region did not have as many big power stations.

However the situation was complicated by the fact that industries in the Vaal triangle were older and did not have the same facilities to disperse their contaminants into the higher levels of the atmosphere.

Wells said the CSIR focus would look at health problems as well as the dangers of corrosion and acid rain that result from industrial pollution. He confirmed reports that forest plantations along the length of the escarpment between the Northern Transvaal and Natal were showing signs of acid rain damage.

The Natal Parks Board has also reported that most of its game reserves have shown signs of acid rain damage to vegetation and the CSIR is planning to conduct further investigation into this danger.

Two separate studies, by Professor Saul Zwi at the University of the Witwatersrand and Professor AM Coetzee of Pretoria University, have found residents of polluted areas, especially young children and older people, are more likely than people from non-polluted areas to develop upper respiratory tract infections.

Fourie said the results of these studies were debatable because they had compared health levels in polluted areas and non-polluted "control" areas without rigorously demonstrating the absence of disease-causing pollutants in the "control" region.

But ear, nose and throat specialists from the Vaal also report a higher incidence of chest complaints in the region than in less-industrialised areas.

A doctor, who cannot be named for professional reasons, said a recent meeting at the technikon in Vereeniging had indicated that one in every four students who came from distant areas began to develop chest ailments after their arrival in the Vaal area.

There was a great danger that repeated doses of sinusitis, blocked noses and sore throats could, if unchecked, develop into chronic cases of emphysema and bronchitis. Tumours of the lung were also potential dangers.

Another specialist noted that serious lung disease in the area are so widespread that the five oxygen tents at the Sasolburg Hospital are always occupied and patients are frequently transferred to Johannesburg and Pretoria for treatment.

Eddie Koch

statement & work out your break-even apply for a business

Sowetan 7/7/89.

Medical ethics study gets R35 000 boost from Biko Trust

A R35 000 cheque will be presented to the dean of medicine at the University of the Witwatersrand, Professor Clive Rosendorff, on behalf of the Steve Biko Trust Fund today.

A spokesman for the university said the money would be divided equally between Wits and the University of Cape Town and would be used to promote the concept of ethics in medicine.

The cheque will be presented to Rosendorff by the Professor of Anthropology, Philip Tobias.

Tobias was instrumental in the Steve Biko case held in the early 1980s in which the South African Medical Council was taken to court over its decision "to do nothing about the doctors who attended Biko while he was dying."

STEVE BIKO

A large number of people from the medical fraternity in South Africa and abroad contributed a substantial sum of money to Tobias, legal advisors and other professors involved in the case to pay for costs.

The council lost the court case and R35 000 left over from donations was put into the Steve Biko Trust Fund. — Sapa.

S 935

Biko medical ethics trust fund

By Jacqueline Myburgh

Almost 12 years after Steve Biko's death the doctors who forced the SA Medical and Dental Council to hold an inquiry into the behaviour of two district surgeons yesterday saw the end of "a series of tragic occurrences" which, according to Dr Phillip Tobias, "severely damaged the integrity of the South African medical profession".

Dr Tobias, former dean of the University of the Witwatersrand's Medical Faculty and one of the "triumvirate" of doctors who challenged the SAMDC in court, handed over a cheque for R17 000 to the present dean, Professor Clive Rosendorff, for use in the advancement of medical ethics in South Africa.

The money was left in a Biko trust fund formed when Supreme Court action against the "Biko doctors" was taken. When the court ruled in favour of Dr Frances Ames, Dr Trefor Jenkins and Dr Phillip Tobias and awarded them costs, the money was no longer needed for the purpose for which it had been donated.

It was decided to divide the money between the University of Cape Town and the University of the Witwatersrand for use by their respective Medical Faculty Ethics Committees.

The gift will be the basis of "The Steve Biko Medical Ethics Trust Fund".

Laboratories to 'reveal all' to public

Medical Reporter

Members of the public who may be intrigued by what goes on behind closed laboratory doors are invited to visit the South African Institute for Medical Research next month where "all will be revealed".

The institute, which celebrates its 75 th anniversary this year, is holding an "Open Week" during which the public will be able to learn more about laboratory technology and medicine.

Visitors can wander through a comprehensive exhibition of various aspects of research including a display of live mosquitoes and scorpions, an exhibit of sexually transmitted diseases and a giant-size model of an Aids virus.

You could also find out what blood group you belong to or take a closer look at paternity testing.

The "Open Week" will be held at the institute, corner of Hospital and De Korte Streets, Hillbrow, from August 12 to 19 (excluding Sunday 13). Gates will open at 9 am and close at 5 pm. Entry is free.

For further information contact Kathryn Roux at (011) 725 0511 x 2269.

Heart disease SA's biggest killer

Medical Reporter Star 19/7/89

More people die of heart disease than of cancer and traffic accidents combined, statistics released by the Heart Foundation of South Africa have revealed.

In South Africa, which has the highest incidence of heart disease worldwide, eight out of every 10 adults have a higher than normal risk of heart attack.

The Heart Foundation in conjunction with a pharmaceutical company has launched an extensive cholesterol awareness campaign aimed at lowering the incidence of heart disease which kills 31 South Africans daily, yet can be prevented.

At a press launch yesterday it was pointed out that by lowering one's blood cholesterol levels just 10 percent, the risk of heart disease dropped by as much as 30 percent.

Too much cholesterol results in fatty deposits in the arteries which may eventually completely block the artery causing a heart attack or stroke. Some cholesterol is manufactured by the body, the rest in taken in with the food we eat. (85)

Stopping smoking, monitoring blood pressure and eating healthier food greatly reduces the risk of heart attack.

The Heart Foundation pointed out that many people believed because they had no physical "symptoms" of heart disease there was no need to check their cholesterol levels. This was erroneous.

Health workers should demand safeguards for detainees

By MOKGADI PELA

HEALTH workers have an important role to play in demanding safeguards for the wellbeing of detainees and an end to detention without trial, says the message contained in a book called *Critical Health*.

The 78-page book exposes the bad health effects of detentions and hunger strikes.

The situation is explained in various articles.

One such article outlines the medical and ethical aspects of detention and hunger strikes.

The author, Professor John Kalk of the Wits Medical School, kicks off by saying the major health impact of detention without trial is psychological as well as psychiatric.

Thus long-term political prisoners are regularly brought for psychiatric services in Johannesburg.

He said experience in working with such patients has led to the development of the concept of "chronic traumatic stress disorder syndrome."

The stress results from the interruption of normal life which includes food, work, study, exercise, leisure and sleep environments.

Common symptoms are depression with insomnia (inability to sleep) and nightmares.

Other complaints include pains, eye problems, pimples, headaches and abdominal pains.

Kalk said detention affected the family and the community and therefore "is an injury to all".

In the light of all these stresses, he said the detainees' motivation for fasting becomes clear and understandable.

When a detainee is on hunger strike he experiences a rapid weight loss of about 3 to 4kg.

Thereafter weight loss is slower with a steady loss of about 300g a day.

Energy during these days is supplied from the breakdown of the body's fat stores, Kalk said.

Deaths

"It normally takes about four weeks to use up these stores in the average well-nourished individual," the author said.

Another article in the book gives a brief profile of detention in South Africa.

Since 1963 approximately 65 people have died in detention with Black Consciousness leader, Steve Biko's death on September 12 1977 being the most highly popularised case.

The article further says there is considerable evidence, given under oath in court proceedings, that torture, both physical and psychological, has taken place as part of "the coercive treatment of security detainees."

The article gives the Supreme Court application by Dr Wendy Orr to prevent security policy in the Eastern Cape from assaulting detainees as an example.

Forster and Sandler in a study of torture in SA reported that 83 percent of former detainees claimed to have been subjected to physical torture.

Namda, at its 1987 conference reported that 72 percent of 303 detainees who consulted health workers after their release, alleged that they had been physically assaulted.

Blacks appeared to be more commonly abused than whites, the article pointed out.

Vivid

A vivid account of the torment experienced by a detainee is given in a note submitted as evidence in the Supreme Court matter of Ebrahim versus the Minister of Law and Order.

In the note Ebrahim described his detention at John Vorster Square thus: "... my interrogators promised to put me under heavy mental strain. W/O Deetlef said if I survived it I would not be a human being."

The article says doctors working in prisons and the military are the ones most likely to find themselves in a conflict over medical principles and ethics.

These doctors may in the course of their duties be called upon to: perform medical examinations of suspects before being subjected to interrogation; attend torture sessions in order to intervene when the victim's life is in danger; treat the physical effects of torture and attend superficially to a seriously injured victim, so that the interrogation can be continued and develop medical and psychological methods which assist those responsible for interrogation and torture.

Coronation Hospital specialist, Dr Yusuf Veriava, concludes the article by saying "there is an urgent need for the medical profession to discuss the dilemmas raised by detention without trial."

HCCC: Health care hobbled by racism

DURBAN. — The Health Campaign Co-ordinating Committee (HCCC) has called for the removal of discrimination in health services and a reallocation of state resources from high-technology, hospital-based curative care to primary health care.

In a statement issued through the National Medical and Dental Association (Namda) yesterday, the HCCC said discrimination in state health services and the unnecessary duplication of facilities due to the formation of racially segregated health administrations had contributed to the increased cost of health care in South Africa, as well as unnecessary distress, mainly to black patients. — Sapa

Medics fear for the sick if conflict breaks out at hospitals invaded by MDM

By MANDLA TYALA

MEDICAL authorities are bracing themselves for a national defiance campaign on Wednesday which, they fear, could disrupt services to the sick and result in turmoil at hospitals if there is conflict between protesters and police.

The Minister of Law and Order, Mr Adriaan Vlok, has claimed that protesters would invade buses and parks on Monday and Tuesday. He said police believed systematic protests would continue up to the election on September 6.

Organisers of the defiance campaign have asked sick black people to present themselves for treatment at whites-only hospitals on Wednesday — the start of a campaign which, organisers say, is aimed at desegregating all public amenities.

Peaceful

Yesterday the organisers announced they would make their campaign an international issue. The Mass Democratic Movement (MDM), a coalition of radical opposition groups, said it had sent a memorandum to world organisations and foreign governments.

It had assured international sympathisers that the purpose of its campaign was peaceful. It also rebutted Mr Vlok's allegations that the protest was a smokescreen for a plan to violently disrupt the elections.

"We are calling on our people to conduct the campaign in an orderly, disciplined and peaceful manner," the memorandum said.

"If the Government persists with its hysterical overreaction, it will have to accept full responsibility for the problems which result.

"The solution is simple — throw open the doors of all segregated facilities to all the people of South Africa."

Meanwhile, in other developments yesterday:

● The Anglo American Corporation, the country's biggest private sector employer, warned that it would take disciplinary action against employees who used facilities to which they were not entitled in terms of their seniority.

Anglo said it noted with concern the defiance campaign called for by the Congress of South African Trade Unions.

It said in a statement: "It is the policy of the corporation to provide facilities, wherever possible, to all employees according to skill and seniority, regardless of race. In an attempt to avoid violence on the proposed campaign, discussions have been held with union officials.

"Management hopes that these discussions will continue in order to resolve specific problems on discriminatory practices through normal and peaceful means.

Lives

"The unilateral and confrontational actions proposed by Cosatu will polarise racial attitudes and jeopardise further progress towards full integration."

● Democratic Party co-leader Mr Wynand Malan appealed to the MDM to reconsider its strategy of using hospitals as a focal point of its campaign.

He said such protests could endanger the health and even the lives of patients.

● The National Medical and Dental Association, an alternative organisation to the Medical Association of Southern Africa, said it supported the defiance campaign.

The eve of the mass protest has seen a spate of bomb blasts on the Reef and an outbreak of violence in the Western Cape.

About 2 000 pupils at Fort Beaufort, apparently jumping the gun, have already marched on a local provincial hospital to demand medical treatment.

While apprehension gripped white hospitals around the country yesterday, a war of words continued to rage between the Ministry of Law and Order and the MDM.

Fines

Mr Vlok has claimed the aim of the protest was to cause a climate of unrest similar to that which prevailed in 1984.

Transvaal health authorities have announced that all hospital premises will be restricted and only those with permission will be admitted.

People defying this rule would be liable to a fine of R2 000 or imprisonment of up to two years.

The MDM accuses Mr Vlok of using untruths to prepare the public for a crackdown on anti-apartheid activists.

An MDM spokesman responded by saying it was clear that health workers and medical people themselves favoured desegregation of health services, and that the Government was the impediment.

Govt ignores apartheid in unequal health care figures

In official publications the picture of black health care being poorer than that of whites is glaring — and the authorities ignore apartheid as the cause, reports **PATRICK LAURENCE**

Racial inequality is the bedrock on which South Africa's segregated health services rest. It is for that reason that the defiance campaign to end apartheid, launched by a loose alliance of organisations known as the Mass Democratic Movement, chose hospitals reserved for whites as the first target in its non-violent campaign.

The arrival of black patients seeking admission at these hospitals yesterday was calculated to highlight the inequality in health care.

The inequality of health services is manifest in nearly all the main indicators of health, says Dr Max Price, of the National Medical and Dental Association (Namda). He lists some of them: life expectancy, infant mortality, immunisation coverage.

His point is substantiated by figures taken from "Health Trends in South Africa", published by the Department of Health and Population Development.

Most anti-apartheid leaders would prefer to use their own figures, arguing that the official data puts too much gloss on the situation. But, even if they do, the sheen does not hide the underlying reality.

Life expectancy

The official publication agrees that life expectancy is a fundamental barometer of health. It quotes the World Health Organisation (WHO) with approval: "Life expectancy at birth, despite its limitations, has time and again been proved to be the most important single measure of the level of health of a population."

Black life expectancy is lower than that of whites: 62 against 71. It is, however, markedly higher than life expectancy in Africa generally — 50,8 — and has improved significantly since 1970 to pass the target of 60 set by the WHO.

Another key indicator is the infant mortality rate, expressed as the number of children who die before the age of one per 1 000 live births.

The infant mortality rate of blacks is considerably higher than that of whites: 61 against just over 9. The black figure is based on an estimate by the semi-official Human Sciences Research Council. Underreporting of births and deaths by black people makes it necessary to estimate.

The Department of Health Publication makes the same points about black infant mortality as it does about black life expectancy: that it is improving, having dropped from 85 in 1970; and that it is much better than the rate of 116 for Africa as a whole.

Child morta'ity, as indicated by the deaths of children between the ages of one and four, reflects similar patterns. In 1986 22,5 percent of blacks who died were between the age of one to four; the equivalent figure for whites was 2,1 percent.

The Department of Health monograph records that child mortality in the black population is decreasing, having halved in seven years. But the observation is prefaced by a qualification: "The rate for South African blacks is based on registered deaths only and the true figure will therefore probably be about 80 percent higher."

Another key indicator cited by Dr Price is immunisation coverage. The Department of Health agrees. It states: "Diseases preventable by immunisation are greatly influenced by primary health care."

Immunisation has brought about spectacular decreases in the occurrence of diphtheria and poliomyelitis in all races. Notification rates per 100 000 people for diphtheria in 1987 were: whites — 0,0; blacks — 0,17. Equivalent Rates for poliomyelitis were: whites — 0,0; blacks — 0.16.

Measles, which can be a killer disease among children suffering from malnutrition, offers a different picture. In 1986 official notification rates for measles were: whites — 5,3: blacks — 40,7. The Department says: "Measles has only been a notifiable disease since 1980, consequently a general pattern has not yet emerged."

The broad pattern of whites enjoying better health and better health services, curative and preventive — and frequently dying from degenerative diseases associated with high living standards — is repeated consistently, irrespective of the indicator chosen.

Take hospital beds per 1 000 for tuberculosis, a disease associated with poor socio-economic conditions: the bed ratio is 4,2 for whites against 8,2 for blacks, coloureds and Asians; tuberculosis notification rates per 100 000 people were 14 for whites in 1986 and 275 for blacks.

Homelands excluded

The figures for blacks are probably worse in all cases because they do not include black people living in South Africa's four nominally independent black states with a total population of 5,5 million. Health and health care in these polities is well below that in South Africa.

A striking feature about the Department of Health's publication is that apartheid is exonerated from blame. The racially different levels of health and health care are seen rather as a function of South Africa's status as country which falls in the "lowest range of middle income countries".

South Africa's health problems are presented as similar to those facing, say, Algeria, Mexico and Panama, all countries with a relatively low per capita GNP and a very high rate of population growth among their poorer citizens.

The Mass Democratic Movement is not prepared to accept that thesis. It sees differential rates of health and health care in South Africa as a direct result of the apartheid policy of creating segregated health services — there are no less than 13 health departments in South Africa — and of allocating smaller budgets to those assigned to blacks, coloureds or Asians.

Shamming costs SA millions

The Medical Association of South Africa says the abuse of sick leave is costing the country millions of rands a year.

A member of the Federal Association of the Medical Association, Dr Edward Barker, said the most common complaint was incomplete sick notes or notes giving incorrect information.

He said there had been cases of doctors issuing false sick notes to attract patients or charging a consultation fee for a sick note.

Assocom's Director of Manpower, Mr Vincent Brett, said the submission of a fake medical certificate could result in disciplinary steps being taken against a worker. This could lead to pressure from trade unions, causing a disturbance in labour relations.

He said the abuse was a management problem and employers should have greater control of productivity.

The Medical Association said doctors guilty of such malpractices were in danger of being removed from the register. — Sapa.

Halitosis, the clinical name for bad breath, may well indicate a dental problem. Decaying food particles between the teeth, a coated tongue covered by a growth of organisms, gum disease and other factors can make breath odour very unpleasant.

These dental problems can be overcome by visiting the dentist or oral hygienist.

Health hazards to the SA working class

Sowetan 24/8/87 - 85

The working class in South Africa suffers more sicknesses and ill health that are scientifically traceable to their material and working conditions, according to General Secretary of the National Council of Trade Unions, Mr Phiroshaw Camay.

He said this at a seminar on "Indoor Air Quality" at the University of Witwatersrand recently.

"Polluted workplaces, stress and hardship are the traditional rewards the working class receives for its labour. Employers have to address themselves fully to this situation and accept responsibility. All life has to be protected," Camay said.

He added that an unhealthy worker working in an unhealthy environment could not be expected to contribute equally. The technical expert's role was crucial in setting the standard.

In the light of these factors which militate against workers' interests, Nactu insisted that management should give shopstewards and members the opportunity to discuss environmental issues.

Nactu inherited a Health and Safety charter from the Council of Unions of SA which insists on every worker having the right to: report safety and health hazards; be protected from victimisation for reporting hazards; information for identifying and labelling of dangerous substances; set standards on health hazards; inspect the workplace for health and safety hazards; accompany state inspectors on their inspections; obtain copies of inspections, complaints and reports; place infringement notices on company notice boards; of access to records of injuries; sue the state for failing to maintain effective standards and participate in annual assessments and studies to improve working life through improving health and safety conditions.

Camay said because nothing much has been done to improve indoor air quality Nactu in conjuction with Wits technicon have sponsored a research programme to cater for this dire need.

"Office buildings which house workers for over 40 hours or more a week may be a home to a wide variety of disease causing bacteria, toxic chemicals and other pollutants," he added.

The air in these buildings can cause headaches, fatigue, sneezing colds, flu and long term respiratory problems.

Indoors

Experts say the sufferers of indoor air pollution include: # contact lens wearers who discover after an ophthalmological examination that the eye pain they experience is due to corneal oxygen deficiency caused by stale indoor air; # users of duplicating machines who experience headaches and fatigue and workers who are poisoned by vapours from fibreboard, office furniture, carpet cleansing residues and office machines.

The causes of outdoor air pollution are open windows and ventilation intakes. Interior air pollution's sources include materials used in building construction and in building furnishings, heating ventilation and air conditioning systems, office equipment cleaning solutions and paints, Camay said.

He pointed out that tobacco smoke was the most prevalent combustion product in indoor environments. Tobacco smoke can cause irritation of the eyes, nose, throat and respiratory tract.

Camay said materials used in the construction of buildings could become indoor pollutants. Asbestos can become dangerous when it disintegrates due to wear and tear.

Regarding preventive strategies, Nactu suggested the use of material that emits no pollutants, particularly volatile organic compounds. Metal is preferable to plastics. It is possible to purchase less hazardous substitutes for indoor environment.

"Nactu is sceptical whether there is widespread awareness among employers, unions, insurers and even the Government that health care plays an important part in the workplace. Health promotion efforts should range from sophisticated preventive health care programmes to simple anti-smoking clinics," Camay said.

Help

As far as health and safety disputes are concerned the federation believes that workers have the right to stop work immediately they detect an unsafe situation. Workers have the right to hold company chief executives responsible for health and safety.

Institute celebrates 75 years medical research

Sowetan 28/8/89.

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The SAIMR is celebrating its 75th anniversary this year. Pic: Joe Molefe.

THE South African Institute for Medical Research (SAIMR) is this year celebrating its 75th anniversary.

From small beginnings in 1914 with an annual budget of R20 000, it is today spending R82 million a year and has 60 branches countrywide.

The institute, which is funded by the Chamber of Mines, the government, goods and services from research and the Medical Research Council, was in its early days mainly concerned with infectious diseases.

A study by a group of mine doctors showed an annual death rate among black mineworkers of 57,7 percent per 1 000 for the period November 1902 to April 1903. Pneumonia and other respiratory diseases accounted for 41,7 percent of all deaths.

However, the institute has since moved to cover all aspects of medicine. These include microbiology, cancer, Aids research, and a pathological laboratory.

With its head office situated at the corner of De Korte and Hospital Streets in Braamfontein, Johannesburg, the institute has a symbiotic relationship with Wits Medical School.

According to the institute's deputy-director, Dr Richard Doering, all the teaching in microbiology, chemical pathology, haematology and other specialist fields at Wits are done by SAIMR staff.

He said vaccine production at the institute has successfully helped in eliminating diseases like diphtheria and whooping cough. SAIMR also

By MOKGADI PELA

provides a diagnostic service which is run by Professor Ruben Sher. The service tests people's blood to detect infection with the Aids virus.

Doering said an even greater contribution was provided by the Aids Training and Information Centre which was established at the beginning of last year. ATIC trains people to teach others about Aids.

Another valuable job was done in the dermatological field where Professor Charles Isaacson researched the causes of skin conditions and finally concluded that hydroquinone was responsible for damaging skins.

In observance of their 75th anniversary the institute recently held an open week where it invited the public to see its work. For the same reason a series of lectures on items of general interest have been conducted. The lectures dealt with heart disease in South Africa (Professor Harry Seftel), Aids (Professor Ruben Sher) and a study of genetics delivered by Professor Trevor Jenkins.

In the light of all these developments it has become clear that SAIMR has helped to raise medicine out of the abyss of tradition, myth, superstition and philosophy into the light of scientific understanding.

A State of health

Sir — The article entitled "The system is sick" (*Leaders* July 28) justifies comment. Under the guise of uncovering flaws and offering the patent solution, it is mainly concerned with approximately 12 of the more than 650 hospitals in this country.

The article does not take into account the National Health Plan, which has been developed to provide a policy for a uniform national health approach and a balanced deployment of health services through co-ordination by the three tiers of government.

It is difficult to ascertain the purpose of the reference to the "all-white hospitals of Durban, Bloemfontein or Port Elizabeth — still today confined behind the walls of the Own Affairs legislation." Those hospitals, classified as Own Affairs Departments of Health Services, are presently still being staffed and managed by the respective provincial administrations on an agency basis.

The government is fully aware of the problems associated with the recruitment and retention of nursing personnel. In a press release on July 17, the Minister of National Health & Population Development instructed the Health Matters Advisory Committee to investigate the matter and to report on methods to promote a more efficient nursing service.

The committee is at present considering a broad strategy which will serve as a policy framework for a balanced process of privatisation of services, in support of the privatisation initiatives being pursued by government. This development is further augmented by an investigation into alternative ways of financing health services in SA. "Health care centres with essential equipment, drugs and staff," as mentioned in the article, are one of the possibilities being investigated.

The Johannesburg Hospital is a training institution for intensive care nurses and, therefore, the statement that "administrators have at times put nurses without any appropriate training in charge of Johannesburg Hospital's intensive care unit" is inconceivable. Hospitals receive funds to buy items such as thermometers on contract. Stories that nurses need to buy thermometers with their own money are unfounded.

The figure of R60 000 quoted as the earnings of a head of a medical department on the joint staff of the Transvaal Provincial Administration and the University of the Witwatersrand is far less than the actual remuneration.

Though beds for intensive care at Johannesburg Hospital have been reduced, there is no possibility of an imminent collapse. This applies to the situation at the J G Strijdom, where arrangements have been made for the haemodialysis unit to continue functioning.

In the Johannesburg group of teaching hospitals, a wide range of diseases is encountered, providing adequate training possibilities — more than 4 700 beds are available, 217 211 patients are admitted and more than 2,6m out-patients are treated annually. It is not clear how a conclusion could be drawn that "Own Affairs health care has crippled the prospects of SA's future doctors."

The estimated patient cost for Baragwanath Hospital for the 1988/1989 financial year is R108 per patient a day and not R45 a day. Furthermore, higher expenditure for the Johannesburg Hospital is affected by the fact that it serves as a tertiary referral hospital (including Baragwanath) for treatment that cannot be got elsewhere, that is, cardiothoracic surgery, renal transplants, renal dialysis, radiotherapy, chemotherapy, haemophilia. There is a dwarfism clinic and nuclear medicine.

Other services rendered exclusively at the Johannesburg Hospital include: the Ambulance Training College; the emergency helicopter service; development of the computer system; honorariums to all junior interns of the University of the Witwatersrand (also those at Baragwanath); and the staff of centralised departments rendering services to other teaching hospitals, including Baragwanath, are remunerated only by the Johannesburg Hospital.

All these costs are added to the expenditure of the Johannesburg Hospital only and contribute to the higher unit cost. No direct comparison can be made between the unit costs of Johannesburg and Baragwanath hospitals.

A unitary health system with a socialistic orientation is propagated in the article by your correspondent, who points to the 85% of whites covered by medical schemes. Yet, when blacks do the same by gaining medical insurance, he laments the fact that costs are rising. He appears to criticise government's support of a shift to private medical care, but is also opposed to the opposite. If it is a unitary system like the National Health System of the UK he wants, your readers have a right to know the cost implications for the taxpayer and the limitations experienced by that system at present.

It is naive to claim that the solution is obvious.

Dr C F Slabbert, Director-General Department of National Health & Population Development, Pretoria.

We need that protection

Sir — I was glad to see you carried "The Case for Local Content" by Trevor Bell (*Business* July 21) almost as a rebuttal of the cover story on the Board of Trade & Industry (BTI) (*Leaders* July 21). I support everything Prof Bell says — without domestic investment, employment and earnings, that is, wealth generation, the SA economy and consumer will be unable to pay for anything, either imported or domestically produced.

The BTI article was unfair. Dr McCrystal's men are simply trying to put SA's interests first in a very complex environment; and, in the international trading arena, it is naive to pin one's hopes on "money left over from buying inexpensive imports and export industries which would develop naturally" should protective and development measures be lifted.

C Murray, managing director, Pilkington Shatterprufe, Port Elizabeth.

Facets of diamond law

Sir — I refer to an article entitled "Deregulation — Rough diamonds" (*Business* August 18) and, in the interests of clarity, would like to place the following on record.

The company has made representations to the Department of Mineral & Energy Affairs concerning the Draft Minerals Bill, and communications thus far have been aimed at achieving a meeting of minds. There has been no formal comment specific to Section 123 of the Precious Stones Act (right of search) or the repeal of the so-called IDB provisions.

De Beers believes that the continuation of the right of search is vital in protecting an important national resource, as well as its commercial interest, especially considering the unique vulnerability of diamonds to theft. It is important to note that all major high-value diamond-producing countries have enacted legislation which prohibits the unrestricted handling of rough diamonds.

It is implied in your article that the diamond laws are seen to have costs to society which are now incompatible with their benefits. The fact is that the loss in revenue to the State in taxation and foreign exchange from diamonds which are stolen is greater than the loss to the producers. The issue thus is not simply a matter of control vs deregulation, and De Beers sees the government and the diamond industry having a commonality of interest in this important matter.

N B Huxham, group corporate communications department, De Beers, Johannesburg.

The FM welcomes letters from readers, but asks that they be kept as short and concise as possible. Letters must carry the name and address of the sender.

The *FM* reserves the right to edit letters

BDay 13/9/89.

Bleak future at Groote Schuur

85

CAPE TOWN — The head of the UCT medical school has warned that the future of Groote Schuur Hospital as a teaching institution could be threatened by staff shortages, lack of funds and the fragmentation of health care in SA.

Interviewed by the Cape Times, Professor S R Benatar said Groote Schuur had not been given the resources to staff all the facilities in the new hospital.

He said, however, that the hospital was "functioning superbly well due to dedicated work by all the staff members".

Groote Schuur — a tertiary hospital — was inundated with cases that could have been cared for at less sophisticated institutions, he said.

He mentioned that the hospital's trauma unit received a particularly high volume of patients who could have been cared for at other institutions — especially on the Cape Flats.

Own Correspondent

When Mitchell's Plain was still in its infancy, "it was a city the size of Bloemfontein with almost no health services", he said.

Health care facilities were less than rudimentary on the Cape Flats and many cases — referred to Groote Schuur — could be handled at community level and at a "much less expensive hospital" than Groote Schuur.

Benatar said that in SA there were 14 Ministers of Health and this showed that the overall planning of health care was fragmented.

"Under the tricameral parliament there is insufficient use of resources."

In an article in the SA Medical Journal, Benatar said the scenario for the future is for teaching hospitals to become large centres for the treatment of the old, the infirm and the indigent by relatively junior medical staff who have little time or inclination for academic activities.

"The workload will be heavy and teaching will lose the lustre that has characterised our medical schools over many decades," he said.

At the current growth of the SA population a new medical school will be needed every three to four years, he said.

To bridge this problem, medical assistants should be trained as auxiliaries, he said.

In spite of the problems experienced, Groote Schuur was still recognised as a centre of excellence worldwide.

"Our cardiac department is capable of doing anything done anywhere in the world," he said, adding that the respiratory intensive care unit was the leading such unit in the country.

Benatar said a solution would be a "unified coordinated health service" without fragmentation of health care as is the case at present.

"Our role in the community must be preserved," he said.

Star 14/9/89

85

Masa protest on shackling of prisoners

By Toni Younghusband,
Medical Reporter

The shackling of prisoner patients was "inhuman and degrading" and not acceptable in medical ethics, the chairman of the federal council of the Medical Association of South Africa (Masa), said yesterday.

In a statement, Dr Bernard Mandell said his view was supported by the World Medical Association.

He was reacting to an SAP statement that while shackling prisoners brought for hospital treatment might be regrettable, it was "unavoidable" in certain circumstances.

Police said escapes from hospitals had reached "alarming proportions", and accused medical staff at certain hospitals of "non-existent co-operation".

"Shackling is not a form of torture. It is simply designed to restrain the patient who is considered dangerous, and/or to prevent escape."

Dr Mandell said it was accepted that where the safety of the public was at risk, the police had a duty to take precautionary measures.

"However, after reports in April that hunger strikers were being shackled to their beds, Masa was assured that such restraints were used in exceptional circumstances only.

He said doctors' duties to imprisoned and detained patients did not differ from those to any other patient.

Dr Mandell said conflict between medical personnel and the police was best resolved through communication.

B/Day 26/9/89 85

2 held after court singing

PRETORIA — Two people who were among 139 scheduled to appear in the Pretoria Magistrate's Court yesterday in connection with Saturday's planned women's protest march were arrested again yesterday after a crowd began dancing and singing in the court complex.

And near the court, Women Against Repression (WAR) vowed to mount another march, after police stopped their attempt to get to the Union Buildings on Saturday.

At a news conference in the Martyrs' Chapel at St Albans Cathedral, which was sealed off with coils of barbed wire by police on Saturday, WAR memebers said they would again not ask for permission for the march because peaceful protest was "a democratic right".

A total of 113 accused were warned to re-appear on November 30.

Provisional warrants for arrest were issued against 25 who allegedly failed to appear.

The National Medical and Dental Association (Namda) yesterday condemned the arrest of doctors and nurses who were providing medical care to the injured after the protests in Pretoria at the weekend.

Six doctors and two nurses were picked up by the police while they applied first aid to victims of police action.

"One doctor was arrested while actually providing first aid to people injured when the police baton-charged protesters. While inside the cells, our members treated 15 people with a range of injuries consistent with baton assaults."

Namda said that while in the cells, the doctors became aware that no medical treatment was available to injured detainees.

Police said yesterday they had defused an potentially explosive situation by acting against the women protesters, who had defied a Supreme Court order not to march on the Union Buildings.

The police statement said media reports of the events on Saturday were conflicting and in some cases, negative.

The statement said although there were always people who were of the opinion that the police either did too much or too little, "the facts prove that there was good planning and discretion on the part of the police to defuse an explosive situation". — Sapa.

Some patients can't afford transport

Crisis for black cancer sufferers

By Winnie Graham

Thousands of black cancer sufferers urgently in need of medical attention are being denied treatment because they have no way of reaching Johannesburg's Hillbrow Hospital, one of two centres in the Transvaal equipped with chemotherapy facilities.

Mr Andrew Childane, a counsellor who works among the hospital's out-patient cancer sufferers, said yesterday the problem had become so acute that medical staff involved with the Oncology Haematology Clinic at the Hillbrow Hospital had established the Themba Support Group (TSG) to help cancer patients and their families.

Dismissed

The majority of cancer sufferers, he said, were from the lower socio-economic group who had no medical aid and virtually no savings to support them through the critical treatment period.

He added: "A large number of our patients are unemployed either because they are physically unable to hold down a job or because they have been dismissed for taking excessive leave while on therapy. Many of the patients are the sole breadwinners of large families."

Transport and hospital costs were placing families under heavy financial strain. In addition, there was a significant time delay of many months before disability grants were paid. These grants were small.

Mr Childane said some patients who arrived at the Johannesburg station were so ill that the walk to the Hillbrow Hospital took more than two hours. Others skipped treatment at the out-patients department because they did not have enough money to pay for transport.

A survey earlier this year showed that 72 percent of the patients expected problems in continuing visits to their clinics, claiming the cost of coming to hospital was a major expense.

"The nutritional status of the patients is the second problem. Patients receive food supplements once a month but this is sufficient for three days only and is usually shared by the patients' families."

He quoted these case histories, illustrating the type of problems cancer patients experienced in reaching the hospital:

● The wife of a Free State farm worker, seriously ill with cancer of the breast, could not come for treatment because her husband had a monthly income of only R15, (plus a bag of mealie meal and powdered milk). "She urgently needs on-going treatment but has no money for transport."

Subsidise

● A cancer-sufferer from Pietersburg, a father of eight, could not keep a job because he was sick. As a result he had no money to travel to the Hillbrow Hospital for treatment.

"There are thousands of cases needing assistance," Mr Childane added. "Our study showed 80,9 percent have an average of four dependents and 38 percent missed their regular appointment either because they were too sick to travel or because they had no money for transport."

The TSG, he said, hoped to raise money to subsidise transport, buy food supplements for patients and their families, subsidise treatment costs and provide educational programmes.

Mr Childane said that up until 1987 transport costs were subsidised but the hospital had been forced to discontinue the service.

End health care duplication — MEC

Star 4/12/89.

By Toni Younghusband,
Medical Reporter

Providing health care for all South Africans regardless of whether they can pay for it is a top priority of the Transvaal's new MEC for hospital services, Mr Fanie Ferreira.

Mr Ferreira (51), who took over from Mr Daan Kirstein on December 1, said in an interview with The Star on the day of his inauguration that he was not sure how this could be achieved but he believed sound business management would be a key to reaching this ideal.

These sound business-management principles would be applied to stringent rationalisation of health services. Although he had had little time to study his portfolio, Mr Ferreira said there was clearly a need to eliminate the duplication of services.

"At present, local-government bodies are involved, provincial administrations, community development departments ... and we are all busy with the same thing. If we could rationalise these energies I believe health services would be more effective and we would save considerable costs."

An accountant by profession, he stressed he was not a doctor and would never try to be one.

"I don't believe a doctor should be MEC in charge of hospital services. This is a position for a businessman."

A man with wide business interests, Mr Ferreira believes his involvement in local government — he served nine terms as mayor of Naboomspruit and was a member of the Provincial Council for Waterberg for five years — will serve him well.

Prevention

Asked whether Transvaal health services might expect a greater budget next year, Mr Ferreira said he was sure his department would not escape the tightening-up of Government expenditure.

"We will have to make up for that by tightening up our administration," he said. This was where his business experience would be most valuable.

Another area of cost-saving was in the promotion of primary and preventive health care.

"We must put a lot of energy into educating every parent and child in preventive health care.

"It is no use our waiting until the patients come to hospital. We must reach them before they become sick," he said.

He saw the critically short-staffed academic hospitals, groaning under heavy patient loads, becoming centres of excellence where only highly specialised medicine was practised.

The balance of patients would be catered for at clinics and regional hospitals where super-tertiary care was not necessary.

Of grave concern to him was the nursing crisis, though he did not believe the standard of medicine had suffered as a result.

"I think a more immediate question is whether we don't have too many academic beds. Again, I must emphasise rationalisation."

He would not be drawn into the issue of desegregated health facilities, saying this was the responsibility of the Government, nor would he discuss the State's privatisation policy.

Of vital importance during the next decade would be an emphasis on individual responsibility for health.

"I get the impression that we are inclined to believe our health is somebody else's problem. If we get sick we phone the doctor or go to hospital. Look at our lifestyles, at the way we eat.

"Most men in this country are kept alive by pills when they reach the age of 50. We must go back to the basics and take better care of ourselves," he said.

If health education at schools was a necessary part of this procedure, he would push for it.

Honest

A dynamic man at the helm of a thriving family business, Mr Ferreira said he hoped to encourage an honest, open relationship with the media.

"I believe in an open situation and I will gamble on trusting somebody. But if that trust is broken it will be a different story. I don't believe in trying to bluff the press," he said, adding he believed it important that he be available for comment after hours and at weekends.

Mr Ferreira is married and has two married children.

HEALTH & DISEASE_GENERAL

1990

Few victories in academic medicine

The past decade has been an uphill battle for academic medicine in this country and the man at the helm of the largest medicine department, Professor Thomas Bothwell, says that there are few victories to celebrate. TONI YOUNGHUSBAND spoke to him.

A major battle with few victories and many challenges is how Professor Thomas Bothwell, head of the Department of Medicine at the University of the Witwatersrand, describes the last 10 years.

For the man at the helm of the country's largest academic medicine department, the 1980's were fraught with hospital staff shortages, mass medical graduate emigration, fragmentation of health services and racial strife.

Head of the department since 1967, Professor Bothwell can recall no highlights of the past decade.

"It's been a bruising experience trying to run a very big academic department. We have many ongoing problems in keeping these hospitals running," he says, outlining the many difficulties plaguing Johannesburg's remaining four teaching hospitals.

"I think it is generally accepted that academic medicine is under major threat. No one can see a clear way ahead under the present system. Some urgent rethinking as to what our goals should be, how we should be funded, what we should teach ... a whole host of things are priorities.

"As far as our own medical school is concerned, academic medicine will only flourish in a unitary health system where access to health care is the same for all population groups.

"The question of integration of all our hospitals has been a major priority of the medical school and of my department but we have not achieved this to the degree that we would wish," he says, adding that as the vast majority of nurses today are already black an integrated hospital system is an obvious priority.

"I want to see a health service without fragmentation and where the basic needs of all communities are met on a non-racial basis," he says.

The brain drain remains a major headache. "It has been bad at this medical school for more than 20 years. No academic school can survive when it's losing its best graduates all the time," Professor Bothwell points out.

He believes the country's critical nursing shortage should be the health authorities' number one priority. "At the end of the eighties we have, at least in the Johannesburg Hospital, a major nursing crisis. Academic medicine is not going to survive without lots of good nurses and our aim for the next 10 years must be to see that the nurses get their place in the sun."

Yet despite the decade's gloom there have been some rays of sunlight for Professor Bothwell.

Research, which he describes as "probably one of the most rewarding parts of my life", continued to play an important role and is still yielding some exciting results.

His research into how the body handles iron dates back more than 40 years and a recent survey he conducted in Gazankulu, Swaziland and among Mozambican refugees has revealed that a problem which was apparently eradicated some years ago is still rife in poverty-stricken rural communities.

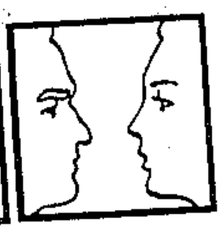
The Medical Research Council unit which he heads discovered a number of years ago that large proportions of SA's black population suffered from too much iron in the body. The iron was ingested through home-made sorghum beer brewed in iron pots. With the passing of the Liquor Act of 1963, the reliance on home-made brews fell away and the incidence of iron overload dropped dramatically in the cities. But this unique condition has again reared its ugly head and is rife among the poor, rural communities to the north. It is a subject that requires urgent investigation.

During the last few years, Professor Bothwell and three other world experts on iron produced a publication for field health workers on iron deficiency which have proved enormously popular and been translated into several languages. "The widespread interest in the topic is due to the fact that iron deficiency is the commonest cause of anaemia in the world."

As he looks to the future, Professor Bothwell believes that while high technology and super specialisation has its place, the emphasis in medicine should be on preventative and primary health care.

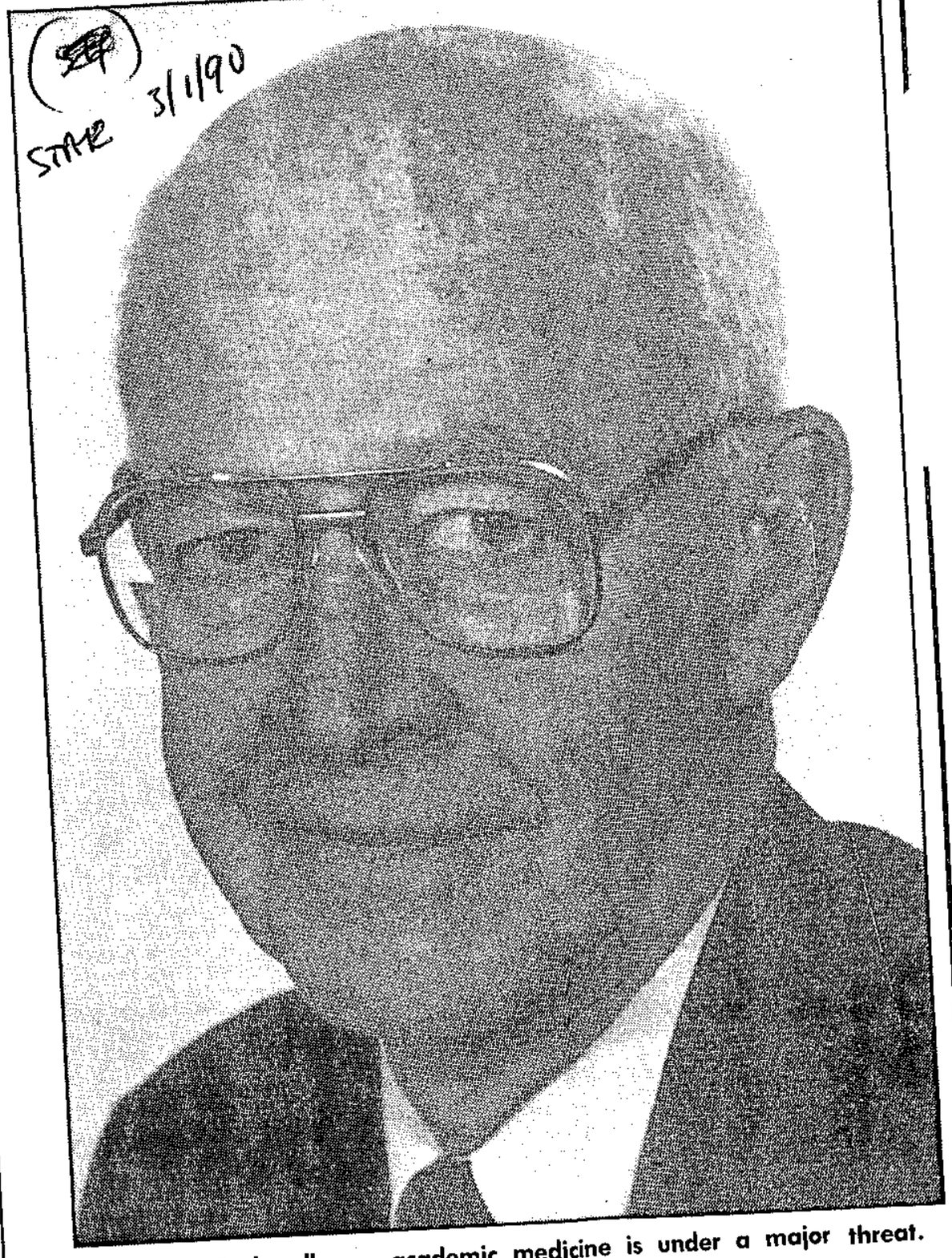
"The medical schools in this country must find some sort of balance between their commitments to high technology and their commitments to primary health care. It is a dilemma which all academic schools in this country are facing."

My Decade 1980s



The 1980s was a momentous decade in world history, but how did it affect individuals? The Star asked several well-known South Africans to look back and say what this past decade has meant to them.

1980: Awarded the SA Medal of the South African Association for the Advancement of Science for outstanding scientific achievements.
1981: Member of the sub-committee of the International Nutritional Anaemia Consultative Group set up to advise the Chilean government on its programme of iron fortification, Santiago.
1982: Elected President of the South African Society of Haematology.
1983: Invited to deliver the guest lecture as the First Clement Finch Visiting Professor at the University of Washington, Seattle.
1984: Awarded the P V Tobias Award for excellence in Clinical Teaching.
1985: Attended the 13 th congress of the International Congress of Nutrition, Brighton, England, as an invited speaker.
1986: Awarded an honorary doctorate in medicine by the University of Cape Town.
1987: Won the SA Medical Research Council's Gold Medal for outstanding scientific achievements.
1988: Received the Biennial Award of the SA Nutrition Society for scientific contributions.
1989: An invited speaker at scientific meetings in Greece, Sweden, Australia and Israel.



Professor Bothwell ... academic medicine is under a major threat.

...appearing in a Pretoria court yesterday on an abduction charge.

Picture: DANIEL SIMON

Health Department to seek budget of R7bn

B/Day 18/11/90 TANIA LEVY

ALMOST R7bn, of which about 70% will go towards salaries, will be budgeted for the National Health and Population Development Department in the March Budget.

National Health and Population Development planning director Johan Kotze said yesterday the estimated R6,974bn budget for the 1990-91 financial year had not yet been confirmed.

If approved in March. the amount will represent a 7% increase on the 1989-90 budget of about R6,483bn.

Family planning, AIDS, immunisation and other community health services are the department's primary areas of concern.

Hospital administration falls under the various provincial administrations.

The Transvaal Provincial Administration (TPA) Health Services Department's budget was about R1,9bn for the 1989-90 financial year.

An original deficit of more than R250m had been reduced to R130m through cost-cutting measures, said Health Services MEC Fanie Ferreira.

● Comment: Page 8

TED reclaims its school desks

B/Day 18/11/90 TANIA LEVY

THE Transvaal Education Department (TED) has removed desks and other equipment from Berea's Barnato Park High School — formerly Johannesburg Girls' High — which opens its doors as a privately run, non-racial, co-educational school next Wednesday.

The 102-year-old school was closed as a government school last December because of dwindling numbers of white pupils. Government refused requests to open the school to all races.

Yesterday TED deputy director Ken Paine said the TED had not removed everything from the school. Certain furniture and textbooks had been leased to the Barnato Park board of trustees.

Mast Education director and consultant to the board of trustees Grant Nupen confirmed the equipment had been leased along with the school property. He said there was nothing sinister about the TED removing equipment.

Nupen said the school would open its doors to 250 pupils in Stds 6, 7 and 8.

Health costs are at 'disturbing level'

BD cm 24/11/90

GERALD REILLY

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

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

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

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

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

Own affairs

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

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

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

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

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

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

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

Health care a 'privilege not a right'

By CLAUDIA KING

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

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

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

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

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

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

Health is no special case when it comes to privatisation

B|Dan 31/11/90.

W DUNCAN REEKIE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Private eyes hired to probe problems

DP warns Govt on health services

STAR 14/2/90 (85)

Fifty-three nurses filed into the public gallery yesterday to hear **Minister of National Health and Population Development Dr Rina Venter** detail steps the Government had taken to alleviate the nursing crisis.

Replying to an interpellation by **Mr Mike Ellis (DP Durban North)**, Dr Venter said the Government recognised the seriousness of the situation regarding the nursing problem and had taken steps in this regard.

Mr Ellis said he wished to warn the Minister and the Government that unless she dealt urgently with the crisis that had arisen in the profession, health services were in danger of collapsing.

Further deterioration

The crisis had not developed overnight. It had been preceded by warnings from medical professionals, politicians and others that health services would collapse because of the poor working conditions and salaries of nurses.

With the introduction of "own affairs" health, and the result of apartheid health practices, the situation had deteriorated further.

It was appalling that years later, exactly the same cases were being made for improved salaries while nurses continued to resign at an accelerating rate and competent recruits to the profession were dwindling rapidly, Mr Ellis said.

The Government was taking advantage of nurses' dedication and devotion to duty, presuming that nurses would continue to play the game no matter how poorly they were paid or how incongruous their conditions of service remained.

Dr Venter said salaries, working conditions and manpower were the problems facing the nursing profession. Nurses' salaries were being investigated and would be included in the Budget.

The Nursing Association had brought further problems to her attention and she had consequently asked the Health Matters Advisory Committee to investigate these problems.

A private firm of investigators had been contracted to make an objective investigation.

The annual growth of the number of nurses was insufficient to meet future needs. In the light of this, a second investigation into the nursing manpower question was being undertaken.

Dr Venter added that problems in the nursing profession should not considered in isolation. Forty-four private hospitals had opened during the past two years, placing a direct drain on nurses from State hospitals.

Dr Willie Snyman (CP Pietersburg) said it was tragic that problems in the nursing profession had been revealed only after the leaking to newspapers of a confidential report on conditions at the H F Verwoerd Hospital in Pretoria.

He said reasons for the deterioration of nursing services included untenable working conditions, low salaries and student-nurse enrolment dropping by between 23 and 30 percent. — Sapa.

Medical ethics 'are in force during conflict'

CAM THIS 16/2/90

Staff Reporter

MEDICAL ethics, specifically confidentiality, are unchanged in periods of conflict, says Dr Leslie London, secretary of the Western Cape branch of the National Medical and Dental Association.

Speaking at a meeting of the Academy of Family Practice, Dr London said on Monday that confidentiality was a central tenet and any infringement of this must be ethically justifiable.

He said it was impossible for a doctor to remain politically neutral when considering the abuse of ethical and human rights, especially in the context of civil unrest where large numbers of people were involved in changing the social order.

"The many ethical codes in medicine create a point of conflict with the laws and political policies of this country — the clearest being the question of racism in the health services interfering with the quality of care given to a patient," he said.

Health crisis: support staff join the fray

Star 19/2/90 (85)(~~83~~)

By Karen Stander

Non-medical staff in the health services have joined the clamour for a better deal as the crisis in the country's health sector continues to be spotlighted.

The nursing shortage was aggravated by a shortage of trained support staff and many of those who filled the vacant positions lacked dedication and experience because of the poor salaries offered, sources said.

Poor salaries led to low morale, leading in turn to a high turnover of staff.

At Baragwanath Hospital in Soweto, over 70 percent of the clerical and administrative staff have less than 12 months' experience, according to the hospital sources.

Support staff make up 43 percent of hospital personnel and include para-medical professions such as physiotherapists, radiologists and social workers as well as administrative and clerical staff, cleaners, kitchen staff, drivers and security guards.

The recent attention given to the nursing crisis has led to a fear that only nurses and doctors will get raises when the Government examines salaries.

BETTER DEAL

Mr Fred van Niekerk, Transvaal chairman of the Hospital Personnel Association of SA, said: "We are asking for a better deal for the whole health family and not just a part.

"Nurses say they are doing tasks which are not nursing tasks, but if the support staff component was bigger they would be able to do more nursing and less other work.

"Every part of the health sector relies upon a complex web of support services.

"If all the money goes to the medical and nursing staff and the other groups get nothing, they will quite rightfully ask 'What about us?' "

This would create destabilisation "unnecessary at this point".

"A hospital must have a closely linked and co-ordinated effort from its staff and if there is one thing that divides staff, it is a salary problem," he said.

Mr van Niekerk said senior staff were earning half of what they could command in the private sector. "When an offer comes, they go. We cannot afford to lose these people, some with 30 or 35 years' experience."

He paid tribute to the dedication of staff in departments such as admissions and the mortuary, which had to run 24 hours a day. They all deserved a better deal, he said.

SA health-care policy 'stresses' self-medication

GERALD REILLY

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

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

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

The study endorsed that self-medication was widely practised.

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

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

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

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

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

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

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

85 Advertising

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

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

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

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

Star 23/4/90 (85)

Govt has plan to 'develop health needs'

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

She was replying, in a second reading debate on the Associated Health Service Professions Bill, to a question from Mr Peter Mopp (LP Border).

He asked whether she had considered recommending to the Cabinet that the own affairs system be abolished in health services, as it wasted millions of rands, and if she had not considered doing so, would she?

Dr Venter said more would be heard on the council's investigation at a later stage.

Not enough attention had given and recognition accorded to the role which the traditional midwife and healer played in providing services.

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

Strategy for health service being created

85

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

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

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

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

She also said not enough attention had been given and recognition accorded to the role which the traditional midwife and healer played. 23/2/90

Regulated

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

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

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

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

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

System must stay, say Ministers

Scrap education, health own affairs — DP's Soal

Health and education should be removed from the schedule of own affairs in the Constitution, **Mr Peter Soal (DP, Johannesburg North)**, said in the House of Assembly yesterday.

Proposing a motion to this effect, he said in the new South Africa which President de Klerk was promising, the country would be unable to continue to afford — politically and economically — the system of own and general affairs.

"In particular the crises which have developed in education and in health care require special attention and there is no doubt in my mind that it is important to remove these two subjects from the schedule of own affairs in our Constitution."

The Government acknowledged that there were problems in the country's health services, but the own affairs health system could not simply be scrapped, the **Minister of Health Services, Mr Sam de Beer**, said in reply.

He said it was a "total oversimplifiction" to suggest this as a solution to a problem which could not be solved overnight.

The country was moving into a new dispensation but it had not arrived there yet. The future had to be addressed "from this base".

Not one member on the Government benches was in favour of discrimination.

Mr de Beer said that this administration aimed to offer inclusive, not exclusive, services at its hospitals.

Own Affairs hospitals could and would render services to other race groups, as had happened at the J G Strijdom hospital where two wards had been opened to coloured people.

In this manner vacant accommodation was presently being used in a meaningful manner and all patients in that hospital were getting a better service.

Mr Soal said that when black education was introduced by Dr Verwoerd, he made it clear that the intention was not to create "black Englishmen" but that blacks were to be equipped to prepare themselves for their position in society as drawers of water and hewers of wood.

"The present system of education therefore is perceived by black people to be a malevolent and deliberate attempt to relegate black South Africans to subordinate positions in society," Mr Soal said.

The lack of trust and faith in the education system was leading to a degree of anger and hostility in the black community which could again precipitate widespread protest and could once more lead to violent conflict.

Groupings in schools should be allowed on a rational basis and not a racial one.

"Now is the time to end the march of folly. Scrap own affairs," Mr Soal said.

No country in the world adopted a general affairs policy on education, the **Minister of Education and Culture, Mr Piet Clase**, said in reply.

He said countries such as the United States, the United Kingdom and Belgium all applied an own affairs approach to their education systems.

Mr Andrew Gerber (CP, Brits) proposed an amendment to the effect that the present Constitution was not working and that the only solution lay in creating a political dispensation for each nation in its own fatherland.

It was a myth to think that equal inputs in education would deliver equal results. — Sapa.

pleted the 125 km course with ease on Saturday
Vauxhall. The annual car race attracted more than

Dental expert to visit 'chocolate tooth kids'

Star 5/3/90 Highveld Bureau (85)

A community dentistry specialist from the Department of National Health is to visit the coalfields south of Witbank this week to investigate the discolouration of children's teeth.

On Friday The Star reported that hundreds of black children living on collieries or farms in the area had serious tooth discolouration.

The children are referred to by their classmates as the "chocolate tooth kids".

The Department of National Health's senior community dentistry specialist, Dr P J van Wyk, said the discolouration could be fluorosis — caused by too much fluoride in drinking water.

An excess of fluoride is sometimes found near collieries, fertiliser plants and steel mills, he said.

"However, it could be a number of other things as well. We'll be taking water samples during our investigation."

Dr van Wyk said little could be done to reverse the damage caused by excessive fluoride.

BARA BAROMETER

IN the week between March 1 to March 7 there was a cumulative bed shortage of 242 beds and a daily average of 34 patients were without beds in the medicine wards at Baragwanath Hospital.

The worst night was on March 5 ~~when~~ there were 58 patients without beds. Star 10/3/90 (85)

The worst overcrowding in a newly extended ward was on March 6 when there were 81 patients in a 64-bed ward which meant 17 patients slept on the floor. A total of 1 214 fewer patients — 173 each night on average slept on the floor, thanks to 11 newly extended wards so far in use.

Health spending goes up to R7bn

MIKE ROBERTSON

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

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

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

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

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

Unions clash over health strike

CAPE TOWN — The Health Workers Union has branded the Public Servants League an enemy of the workers, in a statement released by HWU general secretary Mr H Mohamed in Cape Town yesterday.

This followed several reports from striking workers at various hospitals on activities of the PSL.

"Crimes" of the PSL included scabbing by PSL members, the PSL urging members to return to work despite demands not having been met, intimidation of workers by PSL members, slander of the HWU and "PSL members opportunistically talking to Mr (Charles) van Zyl when the workers unanimously rejected this avenue," Mr Mohamed said.

"The workers do not see the need to talk to the Government, their employer, through an intermediary when it is already aware of our six demands and the demand that we meet directly with the Ministers concerned," he added.

The strike entered its 10th day on Wednesday, and has spread from the Cape Peninsula recently to as far as Vredenburg on the West Coast. — Sapa.

Health allocation is 'misleading'

Star 15/3/90 (Gen 85)

By Toni Younghusband,
Medical Reporter

The 8,6 percent "increase" in the health budget announced by Finance Minister Mr Barend du Plessis yesterday was misleading as health expenditure per capita had in real terms come down by almost 10 percent, Dr Max Price of the National Medical and Dental Association said.

Although the health budget had gone up from R6,5 billion to R7,06 billion, the 16 percent inflation rate and the approximately 2,5 percent increase in population growth meant there was less money to spend on health.

"Given the current crisis in hospitals, this is very dangerous," Dr Price said.

He criticised the Minister's "vague" announcement of pay increases for nurses. "They were told that a long time ago and many of them have been hanging on to their jobs waiting for a real figure to be announced with the Budget. It is an insult not to say exactly what they'll be getting," said Dr Price.

Mr Rob Speedie, the executive director of the Representative Association of Medical Aid Schemes, was "disappointed".

"It is generally accepted that in the health sector the inflation rate is about 20 percent and an 8,6 percent increase just isn't adequate to keep up," he said.

He said population growth exacerbated the problem. "From the private sector's point of view I foresee a bigger load on the shoulders of employers and medical schemes," he said.

However, he did not believe any additional increases in medical aid fees would result as medical schemes had already presented their budgets for the year.

LARGER BURDEN

One noticeable feature of the budget was that the gap between private and public sector health expenditure was narrowing. "The private sector is going to be carrying a larger section of the burden," said Mr Speedie.

He said the 8,6 percent increase would not go very far unless accompanied by very effective cost savings through increased efficiency in State health care. He foresaw a certain amount of privatisation in 1990.

Dr Price said the 11 percent overall increase in social services spending was still 5 percent below the inflation rate and would in real terms be less than the 1989 budget, for a larger population group.

The chairman of the Federal Council of the Medical Association of South Africa (Masa), Dr Bernard Mandell, said that the budgeted 40 percent increase for social services compared to last year's 29 percent of the total budget was encouraging.

He said there was no doubt that South Africa's priorities for the future must be to make adequate provision for health, education and housing to ensure the total well-being of all people.

"South Africa's expenditure of 5,4 percent of the Gross National Product on health is in line with the World Health Organisation target. However, there is no doubt that services are under tremendous pressure and that the needs of a large section of the population are still not being met".

The MEC for Hospital Services in the Transvaal, Mr Fanie Ferreira, said 8,6 percent was quite a substantial increase. For Transvaal health services this would alleviate certain areas of the provincial budget which was experiencing a considerable deficit.

Hospital beds

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

How many hospital beds were (a) available and (b) needed for (i) White and (ii) non-White patients in hospitals falling under the control of her Department as at 31 December 1989? B279E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

No hospitals are at present being controlled by the Department of National Health and Population Development,

(a) (i) and (ii) and

(b) (i) and (ii) fall away.

SABC: broadcasting licences

128. Mr L FUCHS asked the Minister of Home Affairs:

(1) Whether he will reply to questions on whether the South African Broadcasting Corporation has received any applications for licences to broadcast (a) news reports and (b) entertainment; if not, why not; if so, (i) what are the names of the applicants, and (ii) when did they apply, in each case;

(2) whether any of these applications were refused; if so, (a) which applicants are involved, and (b) what were the reasons for the refusal, in each case? B292E

The MINISTER OF HOME AFFAIRS:

(1) (a) and (b).

No. The SABC does not consider applications for licences.

(i) and (ii) Fall away.

(2) Fall away.

Health services: percentage of total cost spent

144. Dr W J SNYMAN asked the Minister of National Health and Population Development:†

(1) What percentage of the total cost involved in health services in the Republic is at present spent on the (a) National Health component of her Department, (b) Department of Health Services and Welfare of each House of Parliament and (c) provincial health services;

(2) in respect of what date is this information furnished? B355E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) Department of National Health and Population Development 6,54%

(b) Department of Health Services and Welfare
- Administration: House of Assembly 6,03%
- Administration: House of Delegates 0,34%
- Administration: House of Representatives 1,54%

(c) Provincial Administrations 73,26%

(2) Allocated amounts for the 1989/90 financial year.

PE/Ibhayi area: school facilities

159. Mr E W TRENT asked the Minister of Education:

Which schools falling under the control of the Department of Education and Training in the Port Elizabeth/Ibhayi area have a (a) library, (b) computer room, (c) science laboratory and (d) domestic science laboratory? B378E

The MINISTER OF EDUCATION:

School	(a) Library	(b) Computer room	(c) Science Laboratory	(d) Domestic Science Laboratory
Newell Sec	1		2	1
Cowan Sec	1		2	1
Itembelihle Compr	1	1	3	1
Isaac Booi Prim	1			
Elumanyanweni Prim	1			
Loyiso Sec	1		2	1

School	(a) Library	(b) Computer room	(c) Science Laboratory	(d) Domestic Science Laboratory
Emsengeni Prim	1			
Ndzondelelo Sec	1		2	
Khwezi Lomso Compr	1		4	1
Mzontsundu Sec	1		1	
Tamsanqa Sec	1		1	
Kwamagxaki Sec			1	

PE/Ibhayi area: school musical activities

160. Mr E W TRENT asked the Minister of Education:

Which schools falling under the control of the Department of Education and Training in the Port Elizabeth/Ibhayi area have a (a) brass band, (b) choir, (c) piano and (d) string orchestra? B379E

The MINISTER OF EDUCATION:

(a) None.

(b) All.

(c) None.

(d) None.

PE/Ibhayi area: platoon system

161. Mr E W TRENT asked the Minister of Education:

Whether any schools falling under his control in the Port Elizath/Ibhayi area operate on a platoon system; if so, (a) which schools and (b) (i) which standards, and (ii) how many (aa) pupils and (bb) classes, are involved in each case? B380E

The MINISTER OF EDUCATION:

(a) (b) (i) and (ii) (aa) and (bb)

	Platoon Schools: Pupils per standards in March 1990												Total	Number of Classes	Platooning with
	A	B	1	2	3	4	5	6	7	8	9	10			
Gqehera	–	–	–	–	–	–	–	885	137	172	–	–	1 194	24	Garret Tamsanqua
Kwazakhele	–	–	–	–	–	–	–	322	238	210	282	262	1 314	20	Nozoncelelo Tamsanqua and Henry Nginsa
Lungisa	–	–	–	–	–	–	–	434	61	50	–	–	545	14	Emafini
Masibambane	–	–	–	–	–	–	–	227	233	228	134	115	937	19	Matodelana
Phakamisa	–	–	–	–	–	–	–	270	165	150	201	72	858	20	Emfunuweni
Sakhisizwe	–	–	–	–	–	–	–	898	132	–	–	–	1 030	19	Isaac Booi
Aarom Gqadu	–	–	–	–	164	187	212	–	–	–	–	–	563	19	W B Tshume
Arthur Nyobo	200	164	180	131	–	–	–	–	–	–	–	–	675	16	Kama
Ernest Skosane	–	–	–	–	69	96	120	266	–	–	–	–	551	12	Ben Sinuka
Jarvis Gqamlana	125	94	114	121	–	–	–	–	–	–	–	–	454	12	Samuel Nongongo
Masanqwana	–	–	–	–	135	258	150	208	–	–	–	–	751	16	Stephen Mazingula
New Brighton	–	–	–	–	106	150	199	245	–	–	–	–	700	17	Johnson Marwanqa
Molefe	–	–	–	–	52	156	189	303	–	–	–	–	700	16	Phillip Wikewe
Phakama	270	223	200	187	–	–	–	–	–	–	–	–	880	19	Emzomcane

HOUSE OF DELEGATES

INTERPELLATIONS

Own Affairs:

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

District surgeons employed

Mr Y I SEEDAT asked the Minister of Health Services and Welfare:

(1) Whether his Department employs any district surgeons; if not, why not; if so, what are the relevant details;

(2) what is the policy of his Department in regard to future appointments of district surgeons?

D78E.INT

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) Yes, full-time district surgeons have been appointed at Chatsworth and Verulam with the consent of the Natal Provincial Administration.

(2) The appointment of district surgeons is the responsibility of the provincial administrations. For the benefit of the community, however, as a supplement to the department's primary health care programme, medical officers are appointed who can do medical legal work in consultation with and with the approval of the provincial administrations.

Mr Y I SEEDAT: Mr Chairman, at the outset I would like to state that this interpellation is not intended to argue the case for Indians to be appointed as district surgeons just because they are Indian. The purpose is to highlight the absence of the service and to focus on the difficulty experienced by our community.

The hon the Minister is the Minister of a department providing a service, as are all other own affairs ministries. Whether a district surgeon provides a service as a medical officer or as a district surgeon, is immaterial. What is important is that the service is taken to the people.

On 11 May 1989 I wrote a letter to the former hon Minister of Health Services and Welfare and I wish to quote from this letter:

> It is imperative that immediate steps are taken to provide all district surgeon facilities in Lenasia. I am astonished to learn that residents of Lenasia are compelled to travel to Johannesburg to receive vaccines when travelling overseas.

In his reply the hon the Minister stated, and I quote:

> The provision of full-time district surgeon services in Lenasia is being investigated and will be discussed at a meeting of the Transvaal Co-ordinating Committee for Health Services in July.

Subsequent to that I have heard nothing from the Ministry of Health Services and Welfare.

This House debated a private member's motion on 21 March 1988 relating to the appointment of persons of colour as district surgeons. I raised this very matter at the Extended Public Committee on Provincial Affairs in the Transvaal. I was told that as of April 1989 the Transvaal Provincial Administration employed 145 district surgeons: Of these 18 were employed full-time, 19 on a part-time basis and 33 on a sessional basis. Three out of the 145 were Indian, which left 142 Whites.

Mr M RAJAB: How many Blacks?

Mr Y I SEEDAT: None. My information is that White district surgeons are employed in all magisterial districts in the Transvaal. I am told that the TPA advertises all vacancies, when these occur, in the *SA Medical Journal*. I know, and I am sure all hon members are aware of it, that historically these appointments were reserved for Whites only. There are areas that fall in a magisterial district that has a White district surgeon and these areas are far removed from city centres.

The people do not reside there out of choice, but because of the racist ideology of group separation. Can we not provide a service in these areas? Surely the hon the Minister can prevail upon the provincial authorities to join forces with his Ministry to address the needs of our people who are crying out for this service.

I conclude by saying that the person appointed need not be Indian. If a Dr Khuzwayo or a Dr Smith practises in an Indian area and he is a successful applicant, then I welcome him, provided . . . [Time expired.]

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, hon members of this House are well aware of the motivation to employ district surgeons in Indian areas. They are mostly for post-mortems and for applications for disability pensions as well. We have had problems that are of a religious and cultural nature.

Views were expressed in this House that in certain areas, where circumstances permit it and provided merit was the sole criterion, Indians appointed as district surgeons would be better able to understand the problems relating to our religion, especially when deaths occur—deaths from accidents and unnatural causes.

I am aware that the appointment of district surgeons is a general affair. However, in respect of Chatsworth, I want to raise certain pertinent questions. Is the hon the Minister aware of the duties of the district surgeon in Chatsworth? Did the hon the Minister get any complaints as to whether the district surgeon was on duty? I have received numerous complaints from old people who applied for disability grants, called at the Chatsworth regional office of our administration with an appointment, and the district surgeon was not there. When they called again the district surgeon was missing.

I am informed that in all the activities in the area during working hours the presence of our district surgeon is not very conspicuous. I know that the hon the Minister investigated whether prescriptions were given to indigenous people at the Chatsworth office. I have a copy of the Press release. However, I believe that somehow this funny business is continuing within the administration. [Time expired.]

Mr T PALAN: Mr Chairman, whilst I concede the information given by the hon the Minister, namely that the appointment of district surgeons is the responsibility of general affairs, will the hon the Minister agree with me that wherever there are provincial hospitals, the district surgeon should be attached to them? I say this because the facilities provided in hospitals can be made available to enable the district surgeons to carry out their duties. This is the case particularly where post-mortems are involved and old people, particularly in rural areas, are experiencing tremendous difficulties where post-mortems are necessary at times. This is especially the case when there are unnatural deaths.

When the district surgeon uses provincial hospitals the facilities make it easier for him to carry out his duties, except that, of course, a police officer has to be present as well as a dissector to perform the autopsy and dissect the body. Here again the availability of facilities at the provincial hospitals will ease the necessity to have the work done much more quickly.

May I ask the hon the Minister in addition whether he has any input in the appointment of district surgeons as far as the House of Delegates is concerned? It is essential that the hon the Minister should work in collaboration with the general affairs department when the appointments with regard to the House of Delegates are made. [Time expired.]

Mr M RAJAB: Mr Chairman, it is my understanding that this new concept of an interpellation was introduced into the Rules of Parliament precisely because it would afford the opposition an opportunity to raise or air issues which were of some immediacy and which the opposition would not have been able to raise because of the business of the House that was being controlled by the Government.

It was my understanding that in the nature of things, the ruling party in the House would not avail itself of this dispensation. If I am wrong, I stand corrected.

The interpellation before this House is, regrettably, in the nature of a question. First of all, I would have thought that the content of the interpellation has already been answered in a previous debate. This could well have been discussed with the hon the Minister in his own caucus. Nevertheless, one particular point has arisen out of the interpellation, and that is the question of the non-appointment of Blacks as district surgeons.

As this House well knows, this is an issue which I raised with the previous Minister of National Health and Population Development, Dr Willie van Niekerk, when we questioned him as to why Black people were not appointed as district surgeons. At that time he gave this House an

assurance that procedures would be set in motion which would entitle Black medical doctors to be appointed as district surgeons. It would seem to me that those procedures were not put into effect. I want to express my regret at this state of affairs.

I would therefore urge the hon the Minister of Health Services and Welfare to have serious consultations with the hon the Minister of National Health and Population Development to ensure that the assurance that was given to this House on a previous occasion, is honoured. [Time expired.]

Mr Y I SEEDAT: Mr Chairman, following upon the hon member for Springfield, I find it strange that he questions an hon member from this side of the House putting an interpellation. I could be wrong, too, but I am sure he is even further off the mark. I do not think there is anything that precludes an hon member from this side of the House from putting an interpellation on the Question Paper.

It is the hon member's contention that this is in the form of a question and could have been discussed in the hon the Minister's office. However, the very fact that he took up a point which arose out of the discussion, and asked the hon the Minister to discuss it with the present hon Minister of National Health and Population Development, is an indication that there is merit in this interpellation.

Procedures were discussed when we discussed the motion on 21 March 1988, because they were not implemented and because no action had been taken. This matter was raised in the interest of the community whom we are representing. [Time expired.]

The MINISTER OF HEALTH SERVICES AND WELFARE: Mr Chairman, in respect of the contributions made here, queries were raised as to whether Black district surgeons could be appointed. There are no restrictions on applications that are put forward for the appointment of district surgeons. My department does make inputs as far as appointments are concerned. In fact, we do pick the best persons, as appointments are based on merit.

The LEADER OF THE OFFICIAL OPPOSITION: That is nonsense!

HOUSE OF DELEGATES

The MINISTER: In respect of the query by the hon the Leader of the Official Opposition . . .

The LEADER OF THE OFFICIAL OPPOSITION: That is nonsense!

The MINISTER: He disturbs me. That is why I cannot give him an answer.

The LEADER OF THE OFFICIAL OPPOSITION: This watch cost R30 000!

The MINISTER: He raised the question of district surgeons in Chatsworth. As far as district surgeons in Chatsworth are concerned, I have actually asked my department to look into the workings of the district surgeon in Chatsworth. In fact, we will take the necessary action to see that he is doing his job. I have taken cognisance of what has been happening.

Mr K CHETTY: He is wasting taxpayers' money!

The LEADER OF THE OFFICIAL OPPOSITION: Are you talking about the hon the Minister?

Mr K CHETTY: Yes, they should fire him!

The MINISTER: I now come to district surgeons at hospitals. It is not necessary for them to be at hospitals, because they can work from a point where they have other duties to perform, besides when they are called upon to perform autopsies . . .

The LEADER OF THE OFFICIAL OPPOSITION: Your district surgeon should examine you! You need examination! [Interjections.]

The MINISTER: As far as I am concerned, district surgeons will be appointed . . . [Time expired.]

QUESTIONS

†Indicates translated version.

For oral reply:

Own Affairs:

Durban Housing Action Committee: meeting

*1. Mr M RAJAB asked the Minister of Housing:

(1) Whether his Department was represented at a meeting in Pretoria with a Government working committee at which the Durban Housing Action Committee was present; if not, why not; if so, when was this meeting held;

(2) whether the affordability of rents in Government-controlled housing schemes was discussed at this meeting; if so, what was the outcome of the meeting?

D38E

The MINISTER OF HOUSING:

(1) No, my Department was not invited.

(2) Falls away.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, arising out of the hon the Minister's reply, is he aware that such a meeting took place and, if it did, who organised it—notwithstanding the fact that the hon the Minister was not invited?

The MINISTER: Mr Chairman, it is true that a statement was released after that meeting—it was broadcast over the radio—which in fact conveyed a message which was not entirely correct. It was at that stage that my Department took up this matter with a view to correcting that statement.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's reply, who organised this particular meeting?

The MINISTER: Mr Chairman, I am not aware as to who organised that meeting.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's reply, is it not correct that this meeting affected a matter which fell directly under the responsibility of the hon the Minister and, if so, did he complain to the relevant authorities that such a meeting should not have taken place without his knowledge or the attendance of any officials from his administration?

The MINISTER: Mr Chairman, the point raised by the hon the Leader of the Official Opposition was in fact taken up and it was indicated to my officials that the press release issued by this party did not convey the nature of the discussions. They gave the impression that they had virtually succeeded in extracting certain concessions, which was not true.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's reply, is he aware of the fact that the meeting may have been arranged behind his back by one of his colleagues?

The MINISTER: Mr Chairman, no comment!

Glendale: low-interest loans for farmers

*2. Mr M RAJAB asked the Minister of Local Government and Agriculture:

(1) Whether farmers in the Secunda area of Glendale have been offered low-interest loans to re-establish their farming activities; if so, (a) how many farmers have been re-established as farmers and (b) what was the total amount of these loans;

(2) whether he will make a statement on the matter? D41E

The MINISTER OF LOCAL GOVERNMENT AND AGRICULTURE:

(1) No.

(2) Yes.

It would be appreciated if the Honourable Member could furnish a detailed map to indicate where Secunda in the area of Glendale is situated. I am unaware of a Secunda in Glendale my constituency where I have lived for the past 46 years.

Mr M RAJAB: Mr Chairman, arising out of the hon the Minister's reply, may I inform the hon the Minister that the name "Secunda" is due to a typographical error on the part of the secretariat. The correct name is the "Segeni" area of Glendale. Now that the hon the Minister is aware of that, could he give us the reply?

The MINISTER: Mr Chairman, I acknowledge that there could have been a gross typographical error of this nature. If the hon member would re-submit his question I will answer it.

Mr M RAJAB: Mr Chairman, further arising out of the hon the Minister's reply, I would like the hon the Minister to concede that the Glendale area is a very small area and that the matters concerning that small area should have been well known to him, more particularly because it is in his constituency and because it is relevant to his Ministry.

HOUSE OF DELEGATES

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

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

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

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

Botswana: two persons held captive

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

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

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

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

B507E

The DEPUTY MINISTER OF FOREIGN AFFAIRS:

(1) Yes.

(2) Yes.

(a) (i) and (ii)

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

(b) Mr Theodorus Hermansen and Mr Johannes Basson.

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

Pietermaritzburg: alternative highway by-pass route

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

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

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

B509E

†The MINISTER OF TRANSPORT:

Yes.

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

(b) The report is expected during April 1991.

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

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

Atmospheric Pollution Prevention Act: amendments

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

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

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

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

B511E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

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

(2) (a) yes,

(b) yes.

SADF: contact with publication/person

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

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

B512E

The DEPUTY MINISTER OF DEFENCE:

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

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

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

One department of health

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

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

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

B513E

†The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

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

(2) no.

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

Heidelberg, Transvaal: autopsy

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

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

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

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

B515E

†The DEPUTY MINISTER OF JUSTICE:

(1), (2) and (3)

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

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

Health staff to march

Star 23/3/90 Staff Reporter 85

Health workers represented by a host of extra-parliamentary organisations will stage a protest march from Coronation Hospital to J G Strijdom Hospital tomorrow to demand a total overhaul of the country's health services.

Organised by the South African Health Workers Congress (Sahwco), the "March for People's Health" was expected to attract widespread community support, Sahwco spokesman and co-ordinator of the march, Dr Aslam Dasoo, said last night.

"For the first time doctors and nurses will march with general health workers."

Dr Dasoo said the marchers would present a list of demands to the Minister of National Health and Population Development, Dr Rina Venter, who "has been petitioned to be present at J G Strijdom".

"Our principal demand is for the creation of a united national health service with free access for all people. This relates to the on-going privatisation of health services which we reject."

pm —

liability of the police had been established.

Hospital boss praises demonstrating staff

PORT ELIZABETH — Livingstone Hospital in Port Elizabeth was brought to a halt for more than two hours yesterday when staff, including nurses and doctors, marched through the grounds demanding attention to their grievances.

When they presented a petition to the medical superintendent, Dr G White, he told them "I am on your side", and complimented them on their orderly behaviour.

The march was watched by scores of patients and was the first in the hospital's 30-year existence.

The march was held under the banner of the Livingstone Hospital Healthworkers' Committee, an affiliate of the National Education Health and Allied Workers' Union (Nehawu). — Sapa.

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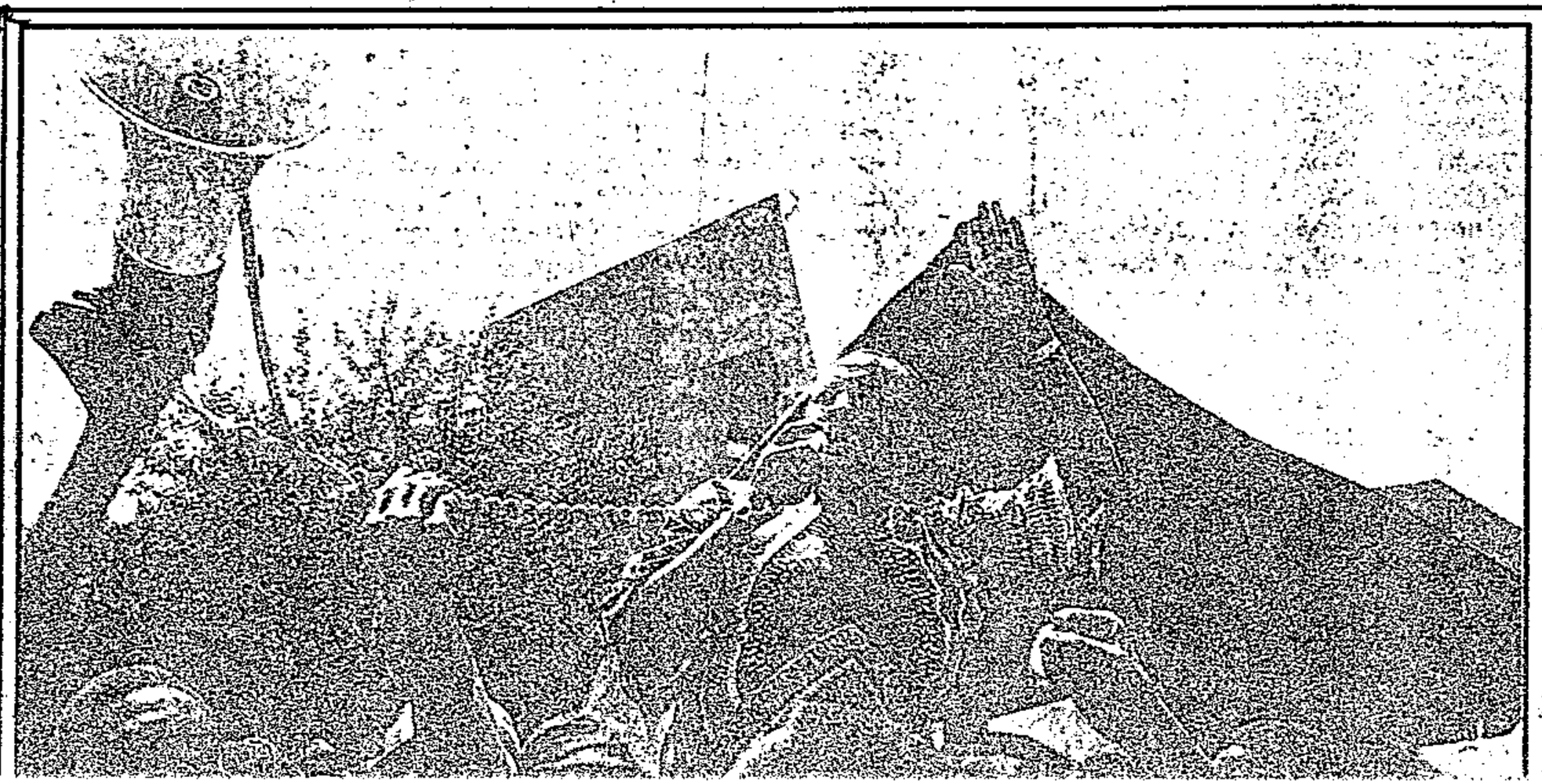
THE CLINIC OF DEATH

c/fiess 25/3/90

Education will get less cash this year than last



Selling coffins is a lucrative, busy sideline

By ELIAS MALULEKE

A CHURCH "clinic" in the eastern Transvaal without a single doctor or nurse has been described as a "death factory" from which very few patients emerge alive.

The clinic, in Green Valley near Bushbuckridge, treats patients for serious diseases like TB, strokes and cancer, and also admits mental cases and paraplegics – but there is no medical

Press 25/3/90

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Selling coffins is a lucrative, busy sideline

By ELIAS MALULEKE

A CHURCH "clinic" in the eastern Transvaal without a single doctor or nurse has been described as a "death factory" from which very few patients emerge alive.

The clinic, in Green Valley near Bushbuckridge, treats patients for serious diseases like TB, strokes and cancer, and also admits mental cases and paraplegics – but there is no medical supervision.

The Nazarene Revival Crusade Clinic is owned by a businessman and spiritual healer, Pastor Benjamin Silinda, 66, who also runs a thriving business selling coffins and has his own mortuary.

Although there is an admissions book at the clinic there is no discharge book.

Silinda claims he speaks to God and has supernatural healing powers. He is a millionaire who runs his business empire with his wife and close family members.

Among his businesses are chains of supermarkets, taxis, hardware stores, a filling station and other businesses in the Acornhoek, Lebowa and Bushbuckridge areas.

He is head and founder of the Nazarene Revival Crusade Church.

There are no doctors to examine the patients before their admission. There are children and youths at the clinic, but most are elderly people.

The catch, people say, is that Silinda has a mortuary on the clinic premises, which also houses the church. Silinda sells coffins at his huge supermarket nearby. The coffins range from as little as R200 to R2 500. He is also alleged to charge storage fees at the mortuary.

His employees at the supermarket said selling coffins was big business.

Investigations by *City Press* have revealed that although there is a register for patients admitted to the clinic, no such records are kept for "discharged" former patients.

Maria Nkhwashu, a clerk at the clinic, said since she took over the

■ To Page 2

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bjections to resigning, my work, but we want natter with the people

lum raised dissatisfac- tortage of housing in vatisation of certain s. It also called for e Johannesburg and

25/3/90

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l set up local offices in the coming weeks to ry assault, every rape, child labour was re- se "evil practices are

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were "dying" and the

No discharge register at clinic

■ From Page 1

An employee with one of the best-selling lines in Mabaso's supermarket – coffins for the "patients".

books last year she had never seen a discharge book, but patients coming in were recorded in the register for their next-of-kin to sign. Asked why there were no home addresses of patients, she said she only noted names of their next-of-kin and place of origin.

Patients are coming in from all over the country, as well as Swaziland and bordering homelands.

On our arrival at the clinic, we found patients being driven to a frenzy in a huge church hall by a female preacher. Some could hardly walk, another was on a stretcher and those who could not make it to the church were left behind in their rooms.

Silinda employs five preachers to perform "miracle cures" because it is alleged he is too busy to pray for the patients himself.

Juta Mabaso, the senior preacher and head of the clinic, said total obedience was expected at the clinic and those who broke the rules, including priests, were sacked.

Alcohol, smoking, love affairs and truancy are outlawed at the clinic. Those who want to get married must obtain approval from the spiritual healer.

An Acornhoek police spokesman said he was not aware there was a mortuary or clinic on the church premises.

"All I know is that Silinda is praying for members of his church – this is news to me."

He was not aware of any deaths from the clinic having been reported at the police station, which is only 500 m from the mortuary. He said the police would investigate whether the clinic and mortuary were registered.

Silinda declined to comment but his business associate, AS Khuthoane, threatened *City Press* with violence.

He said: "We do not want anything published in the newspaper and I can shoot you, burn your car and the police will not do anything about it."

He said if the report was published action would be taken "and not even the police will give you protection; you will be protected by a grave".

The wife of the faith healer, Pauline Silinda, said the mortuary catered for the Green Valley community and not only for patients at the clinic.

"We are in a Catch 22 situation here. Some of the patients brought to us are very sick people who cannot be healed but we cannot turn them back because their relatives will say we are only interested in healing certain people only.

"We admit them hoping God will save them and if they die we cannot be held responsible. Coming here is no guarantee of eternal life. We are all going to die, one way or the other – and that includes my husband."

Silinda also allegedly exploits more than 300 employees under the guise of Christianity. Most are members of his church earning between R60 and R100 a month and many of them are living among the patients.

"They say we are working for God and we will have our rewards in Heaven," said one worker.

Political comment and newsbills by K Sibiya, headlines and sub-editing by K Naidoo, both of 204 Eloff Street Ext, Johannesburg.

Patients wait in the chapel for "miracle cures".

Chief priest Juta Mabaso prays for a cure.

Bill to give more power to medical disciplinary body

85

LESLEY LAMBERT

CAPE TOWN — New legislation has been proposed to enable more effective reaction by the Medical and Dental Council to unprofessional conduct by doctors and dentists.

A Medical, Dental and Supplementary Health Service Professions Bill, tabled in Parliament yesterday, has proposed that the council's disciplinary committee be empowered to apply penalties for unprofessional conduct by doctors or dentists with immediate effect if it is in the public interest.

13 Dag 4/4/90

Order

Under the current legislation, the disciplinary committee has the power only under certain circumstances immediately to protect the public from a practitioner it has found guilty of misconduct.

In terms of one section of the Medical, Dental and Supplementary Health Service Professions Act, the committee may order suspension or conditional practice only with the council's approval. Another section empowers it to act immediately to protect the public.

The amendments are intended to remove this anomaly, according to the legal draftsmen.

The Bill also proposes that the council be entitled to levy fees, according to the seriousness of an infringement, for the restoration of a practitioner's name to the register when it has been removed.

Another proposed amendment is that provision be made for the council to impose fines of up to R10 000 for infringements for which existing penalties of a caution, a reprimand, suspension or removal from the register are either too lenient or too harsh.

For less serious infringements, the council proposes the imposition of admission of guilt fines of up to R500 and the scrapping of appearances at inquiries.

The council is currently represented by four medical practitioners and one dentist, designated from the staff of universities at which faculties of medicine and dentistry have been established. It proposes the appointment of another dentist to alter the ratio and improve the representation of dentists.

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

Pictures: ROBERT BOTHA

Medical scheme starts its own airborne rescue service

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

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

DANIEL FELDMAN

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

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

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

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

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

State and markets both have role to play in health care

BDay 18/4/90.

MIKE MULLER

85

A MAJOR meeting on post-apartheid health policy has just been held in Maputo. That it was held there rather than in SA is symbolic of the distance that separates the domestic parties in this critical policy area, as well as a reflection of the speed of change.

The delegates from the Frontline health ministries, the ANC health department, internal organisations and professional groups debated, among other things, lessons from the experience of the Frontline states — experience based on the principle of "health for all" which South Africans would be rash to dismiss.

Meanwhile, our health industry appears determined to follow its current path of "health for some", with medical aid schemes clamouring to offer preferential rates for low-risk members and to hell with the rest. But it follows this path at its peril, given the existing problems of free market medicine.

These begin at birth, as illustrated by the decision of the SA Society of Obstetricians and Gynaecologists to revise its fee system. This revision attempts to deal with suggestions that caesarean deliveries might be performed for financial rather than clinical reasons. "A global fee for confinements was decided upon in an attempt to lower the extremely high number of caesarean sections done in private practice," it explains in its recent Guide to Fees review.

The would-be free market midwives of the new SA economic order should take heed. If they thought through the implications of this symptomatic piece of voluntary regulation, they might reconsider the more extreme of their policy prescriptions lest the baby they deliver is a mutant monster.

The debate about how to provide health care in a new SA, including articles in Business Day over the past few months, has important implications for many other areas of life. In particular, it highlights the caution needed in addressing the vexed and central question of the role (if any) of the state. Essentially, the debate is between those who believe in the cure-all of the market and those who prefer their prescriptions to be rather more specific.

Prof W Duncan Reekie of the Wits Business School set the ball rolling (Business Day, January 31) with a fervent plea for deregulation of medicine. "Health care is not a special case," he argued, adding that you don't understand much about how a CD player works when you buy it, either.

Prof Reekie has a long track record of defending the existing system of private health care and promoting the further extensions of privatisation and deregulation. He believes that "only deregulation can permit us to find the best system or (more likely) the optimal plurality of systems".

What Reekie ignores, however, is the evidence which we already have. Last year he argued in the SA Medical Journal that over-the-counter medicine from chemists provided good, cost-effective treatment. The economics looked compelling; the facts are not.

Take the survey published in the SA Medical Journal in November 1989, which showed that more than 60% of Johannesburg chemists recommended the wrong medicine for children with diarrhoea. The products some of them offered are not only ineffective; they are well known worldwide to be potentially dangerous, in the extreme, fatal; more efficacious remedies are widely known but not very profitable to sell.

"These findings are perturbing, because acute diarrhoeal disease is the biggest cause of mortality of children aged one to four years in SA," comment Dr Peter Barron and his students from the Wits Department of Community Health, who conducted the survey.

A senior pharmaceutical professional commented, anonymously, that the situation revealed by the survey was "unforgivable". The problem was that those in the chemists' business were schizophrenic, professionals who had to give sound advice but also businessmen who had to sell medicines to make a living. His only consolation was that doctors' prescribing for the same condition was just as bad.

There are many more examples. But for the purposes of the present debate, what matters is whether the end results are acceptable — and they are not. SA was recently relegated by the World Bank from upper-income to the medium-income developing country league; but we don't even look good when we compare lemons with lemons.

Although SA is near the top of the 35-country medium-income league, with Brazil and Malaysia, our life expectancy and infant mortality figures fall in the bottom quarter with those of the Philippines, Zimbabwe and the Dominican Republic. This is despite the fact that we spent about the same proportion of GNP on health as do the other countries — that is, we spent more per head than poorer countries but got less for our money.

Extreme, untested prescriptions in the vein of "let the market take the strain" are not the answer. Suggestions that medical aid schemes should be deregulated so that they can offer reduced premiums to low-risk groups are dangerous nonsense which would leave more people dependent on the state.

Health is a basic social goal and international experience is that some form of co-operation is necessary if basic health care is to be made available to all. This does not mean that all health care must be provided by the state. The state need only give the private sector a framework in which to operate — by obliging medical aids to opt into, rather than out of, high-risk care and thus enlarging the community which can pay its own way.

A compulsory national health insurance system to which all wage earners would have to contribute has been mooted. This would firstly ensure that those with means covered themselves for health risks. Secondly, it would ensure competition.

Present medical aids are too small and too many to match the might of the providers. So a national scheme would not just pay health bills. It would use its strong central bargaining position to ensure that the health consumer got value for money in a market in which the role of consumer (usually a doctor) and provider (also a doctor) are today hopelessly mixed up.

Services could continue to be provided by private enterprises working in a market environment. The existing medical aids could act as agents for the national system.

It has authoritatively been suggested that savings from such a compulsory insurance system could pay for a parallel health-care system for the indigent. Intelligent state intervention would thus use the market to achieve its social goal. It would bring more people into self-financed health care and minimise the residual burden for the state which will always have to provide for the rest — for Ken Owen's "poor lunatic, always last in line" (Business Day, March 6).

The market mechanism can undoubtedly promote economic growth; this in turn may well improve the welfare of the community. But health, in its broadest sense, is a welfare objective which can and should also be addressed directly, by efficient health services. Why go the long way round?

☐ Mike Muller, development specialist and author of The Health of Nations, has written extensively on international health policy.

Call for equal services

85
Sowetan 18/4/90

Sowetan Africa News Service

MAPUTO - An international conference on health in Southern Africa has called for the transformation of South Africa's health and social services into "a non racial, accessible, equitable, cost-effective and democratic national health and welfare system."

The conference drew together a large numbers of health workers and anti-apartheid activitists, members of the ANC and representatives of the Frontline states.

In its final declaration the conference said priority in South Africa should be given to "the development of a progressive primary health care strategy as the basis for the provision of health and welfare services."

It stressed "the importance of making realistic assessments of the resources required for meeting national health and welfare needs equitably, and researching means for mobilising such resources."

Code 22 (Matriculants)

Percentage	*Number*	*Amount*
100%	21	R24 983,79
90%	0	0.00
80%	0	0.00

Code 23 (Lower than matric)

Percentage	*Number*	*Amount*
100%	11	R11 179,44
90%	0	0.00
80%	0	0.00
Total		R109 948,65

Military pensions

209. Mr R M BURROWS asked the Minister of National Health and Population Development:

(1) Whether her Department administers the payment of military pensions to persons injured whilst in military service; if so, (a) what number of persons receiving military pensions falls into each specified category of payment and (b) what total amount was paid out to persons falling into each such category;

(2) whether these categories of payment are based on the educational qualifications of the pensioners concerned; if so,

(3) whether her Department has been involved in discussions regarding the abolition of the educational categorisation of military pensioners; if not, why not; if so, what was the outcome of the discussions?

B490E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes,

(a) persons with;

— a university degree or equivalent	337
— matric or equivalent	964
— lower than matric	6 555
protected cases (previous dispensation)	84

(b) information regarding each category is not readily available. An amount of R3 985 338,28 was paid out in January 1990 in respect of all military pensioners, including widows and other dependants,

(2) yes, except for the 84 protected cases,

(3) yes, a committee has been appointed to investigate the basis on which military pensions are determined. The committee's investigation is still in progress.

Hospitals

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

Which hospitals fall under the control of (a) her Department, (b) own affairs ministries, (c) the provincial administrations and (d) any other specified controlling bodies in South Africa?

Hansard 23/4/90 B494E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

Hospitals (except private hospitals) under the control of:

(a) Department of National Health and Population Development: none,

(b) own affairs administrations:

— Administration: House of Assembly

Transvaal:

Andrew McColm
Bloemhof
Delareyville
Duiwelskloof
Evander
Elsie Ballot
Groblersdal
Hendrik van der Bijl
Kempton Park
Paardekraal
Pretoria West
South Rand
Ventersdorp
Far East Rand
Warmbaths
Willem Cruywagen
Bernice Samuel
Brits
Discoverers Memorial
Edenvale
F H Odendaal
General De La Rey Memorial
H A Grové
J G Strydom
Louis Trichardt Memorial
Phalaborwa
Sybrand van Niekerk
Van Velden Memorial

Vereeniging
Voortrekker (Potgietersrus)
Waterval Boven

Orange Free State:
Bethlehem Prov Hospital
Jagersfontein
Sasolburg
Voortrekker (Kroonstad)
Zastron

Cape Province:
Port Elizabeth
Volks Hospital (Cape Town)
Walvis Bay
William Slater

Natal:
Hillcrest
Greys
Greytown

— Administration: House of Delegates

none,

— Administration: House of Representatives

Lentegeur Hospital
Mitchells Plain Hospital
Dental and Oral Hospital of the University of the Western Cape,

(c) provincial administrations:

Subsidised Hospitals: Cape Province

Booth Cape Town
Maitland Cottage
Sarah Fox (Athlone)
Uniondale
Moorreesburg
Clanwilliam
Laingsburg
Vosburg
Brandvlei
Williston
Hopetown
Richmond
Kenhardt
Warrenton (Prov)
Harmonie Kimberley
Olifantshoek Nursing Home
Stella
Lady Grey
Aliwal-North
Indwe
Komga
Martjie Venter (Mem)
Molteno
Adelaide
Aberdeen
Willowmore
St Monica's (Cape Town)
St Joseph's Philippi
Villiersdorp
De Doorns
Radie Kotze
Fraserburg
Prince Albert
Murraysburg
Loeriesfontein
Carnavon
Britstown
Keimoes
Pofadder
Jan Kemp
Helen Bishop (Kimberley)
Bray
Piet Plessis
Jamestown
Dordrecht Memorial
Maclear
Stutterheim
Sterkstroom
Newhaven (East London)
Kirkwood
Jansenville
Kareedouw

Provincial Hospitals: Cape Province

South Peninsula Hosp Group
Somerset
Groote Schuur (Oat Ward)
Peninsula Mat (Groote Schuur)
Redcross
Conradie
Karl Bremmer
Somerset West
Caledon
Bredasdorp
Knysna
Mosselbaai
Oudtshoorn
Worcester
Robertson Prov
Malmesbury
Vredenburg
Citrusdal
Springbok (Dr Van Niekerk)
Beaufort West Prov
Calvinia (Voortrekker)
Prieska (Bill Pickard)
Colesberg Prov

Upington (Gordonia)
Douglas (Hester Malan)
Hartswater
Kuruman
Vryburg Prov
Aliwal Prov
Steynsburg Prov
Elliot
Queenstown
King William's Town (Grey)
Fort Beaufort
Middelburg Cape
Somerset East
Humansdorp
Dora Nginza (PE)
Day Hospital Org
Mowbray Mat (Groote Schuur)
Woodstock
Avalon
False Bay
Tygerberg
Stellenbosch
Paarl
Hermanus
Swellendam
George
Riversdale
Ladismith Prov
Ceres Prov
Montagu
Porterville Prov
Westfleur
Vredendal
Garies
Victoria West
Sutherland
De Aar (Central Karoo)
Noupoort
Kakamas
Barkly West
Kimberley
Postmasburg
Reivilo Prov
Burgersdorp Prov
Barkly East
Cathcart
Frere
Grahamstown (Settlers & Port Alfred)
Bedford
Cradock
Graaff-Reinet (Midlands)
Livingstone None European
Uitenhage

Subsidised Hospitals: Transvaal

Coligny
Pongola (SA First Aid)
Alldays (Mat)
Thabazimbi Mine
Derdepoort Mission
Alexandra Health Centre
Ottosdal Nursing Home
Messina
Ellisras Clinic
Suid-Afrikaanse Maternity Home
St Vincent
Zuid-Afrikaans

Provincial Hospitals: Transvaal

Kalie de Haas (Potchefstroom)
J D Verster Prov
Schweizer Reneke Prov
Paul Kruger Memorial Prov
Klerksdorp Prov (Tsepong)
Bethal Prov
Volksrust Prov (Amajuba)
Ermelo Prov
Witbank Prov
Rob Ferreira
Sabie
Pietersburg
H F Verwoerd
Laudium Prov
Hillbrow
Natalspruit
Tembisa
Dr A G Visser
Mamelodi
Nic Bodenstein Prov
Christiana Prov
Zeerust
Standerton Prov
Carolina Prov
Piet Retief Prov
Middelburg Prov
Barberton
Lydenburg
Phalaborwa
Kalafong Prov
Baragwanath
Johannesburg
Boksburg Benoni
Nigel
Coronation

Subsidised Hospitals: Natal

Phoenix
St Mary's Mission (Marianhill)
Both's Hill (Don McKenzie)
Siloah
St Aidan's Mission
Zuid Afrikaans
McCord Zulu
Mountain View
St Mary's Mission (Melmoth)
Dayanand Garden Home for the Aged.

Provincial Hospitals: Natal

Addington Prov
Wentworth
R K Khan Prov
Northdale Prov
Port Shepstone Prov
Usher Memorial Prov
Christ The King Mission
Ladysmith Prov
Bruntville
Utrecht (Niemeyer Memorial)
Vryheid Prov
Eshowe Prov
King Edward VIII
Clairwood Prov
Stanger Prov
G J Crookes Prov
St Andrews Mission
Tayler Bequest Prov
Richmond Prov
Estcourt
New Castle Prov
Dundee
Empangeni (Lower Umfolozi)

Provincial Hospitals: Orange-Free State

Odendaalsrust Prov
Virginia
Parys
Bothaville
Phekolong
Vrede
Reitz
Ficksburg Clocolan
Pelonomi
Nasionaal
Welkom
Boitumelo
Heilbron
Hoopstad
Harrismith
Frankfort
Senekal
Winburg
Ladybrand
Universitas
Smithfield

(d) none.

Trauma units

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

(1) (a) How many (i) State and (ii) private trauma units are there in each province and (b) where are they situated in each case;

(2) whether there are any plans to establish further trauma units in South Africa; if so, what is the anticipated cost of each?

B552E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1)(a)(i) and (ii) and (b)

	Number of Trauma Units		
	State	Private	Situation
OFS	20 Out patient div's where emergency cases are treated	Unknown – no record	Throughout the province
Cape	147 Out patient div's where emergency cases are treated	Unknown – no record	Throughout the province
Trans-vaal	– 1 Specific unit – Trauma patients admitted to all general hospitals	Unknown – no record	– Johannesburg Hospital – Throughout the province
Natal	None, Trauma patients admitted to all general hospitals	None	Not applicable

(2) yes,

OFS	No plans
Cape	Yes, cost unknown
Transvaal	No plans
Natal	– King Edward VIII ± 1991/92, estimate: R800 000 – New Durban Academic Hospital ± 1998, estimate: R2 000 000

Noristan acquires Crest

Star 24/4/90

By Jabulani Sikhakhane

Noristan Holdings has reached an agreement in principle for its subsidiary, Aurochs Investment, to acquire 100 percent of Crest Holdings for R7,2 million, which is the equivalent of 105c per share. Crest's share price closed at 85c yesterday.

The acquisition is in line with the policy to change the nature of Aurochs' business from that of a property company to one operating in the health care industry.

The finalisation of the transaction is subject to the major licensor, which is represented by Crest, agreeing to the transaction and transferring its licensing and distribution agreements.

In terms of the transaction, effective from October 1 last year (the beginning of Crest's current financial year), Crest shareholders will receive R46,50 in cash and nine Aurochs shares for every 100 Crest shares held. Aurochs shares will be issued and allotted at 650c each and the listing of Crest will be terminated on completion of the transaction.

Aurochs, which will own 100 percent of Crest, will have cash or near cash of R12,5 million from the sale of its property subsidiaries by no later than June 30 1990 to Hunts (an FSI company) for R15,7 million.

Citizens (a 55 percent subsidiary of W&A), which owns 20,1 percent of Crest, will hold 124,270 shares in Aurochs and cash resources of R4,8 million. If no suitable investment opportunity for Citizens is identified before the completion of the sale of its holding in Crest, Citizens will become a cash shell and its listing will be suspended.

Star 24/4/90 (304A) (85)

Abortion: a new look at present law invited

Own Correspondent

CAPE TOWN — The Government is to take a new look at the controversial Abortion and Sterilisation Act of 1975 and has called for people to approach the Department of Health to put forward their ideas for possible changes.

The Act forbids abortion in South Africa unless the woman has been raped, the baby is abnormal in some way or a medical panel agrees that having the baby will irreparably damage the woman physically or mentally.

The Government decision has been welcomed by the Abortion Reform Action Group which issued a plea to all interested parties to accept the Department of Health's invitation.

"Before the 1975 legislation was promulgated, South African women and men and their organisations took no active part in the abortion debate," said Dr Marj Dyer, chairman of the Cape branch of the organisation.

"If they had, it might have prevented the restrictive law which has led to many deaths and much ill-health, especially among poor women."

Rich go overseas

The financially better off women have made ample use of overseas abortion facilities, she said.

"A woman who does not want to be pregnant doesn't worry about the law. If she can't get an abortion legally, she'll get it illegally. But illegal abortions are frequently dangerous and can lead to death, hideous infections, hysterectomies or infertility.

"We believe the decision to have an abortion should be taken, up to about 12 weeks of pregnancy, by the woman and her doctor."

Pro-Life could not be reached for comment.

Anyone wishing to make representations to the Department of Health should write to the Director-General, Department of National Health, Private Bag X63, Pretoria 0001.

farmers. Audit fees were R3m. — Sapa.

allowances for border

Ban on hydroquinone surprises Twins

TANIA LEVY

MEDICAL professionals and consumer organisations have scored a victory in the skin lightener "war" with National Health and Population Development Minister Rina Venter's decision to ban the use of hydroquinone in cosmetics.

Venter announced in the Government Gazette her intention to remove hydroquinone from the scope of the Foodstuffs, Cosmetics and Disinfectants Act. This means products containing hydroquinone will have to be registered as a medicine and be subject to more stringent control.

Dermatological Society of SA president Mary Ann Sher yesterday welcomed the announcement as it was something organisations such as the Medical Association of SA and the Black Consumer Union had been trying to achieve for two years.

She said research had shown about 30% of black women in the PWV area had irrevocable skin damage from using products containing hydroquinone.

Twins Pharmaceuticals — which has about 75% of the R80m a year skin lightener industry — has been taken by surprise by the announcement as the ban on skin lighteners had originally been postponed to January 1 1991.

Twins marketing GM Maurits Rood said government could lose R28m a year in taxes from the skin lightener industry if the ban succeeded in stopping sales.

He said Twins would apply for some of their strong brand name skin lighteners to be registered as a medicine. Others would be marketed — without hydroquinone — as complexion creams.

He said the key question was the date when Venter's intention would be formalised.

Star 25/4/90 (85)

Attitudes to health service must change — Venter

STELLENBOSCH — Nothing had come of the high ideals of the national health service facilities' plan accepted by the Cabinet in 1980, nor of its aims to make necessary services accessible to all, the Minister of Health, Dr Rina Venter, said yesterday.

She told a medical seminar at the University of Stellenbosch that the plan remained "just a vision", and there had still been no success in obtaining an acceptable balance between primary health care and hospital services.

Success with the implementation of primary health care services demanded a fundamental change in attitude.

"As long as you and I — the planners of health services — carry on erecting luxury hospitals, there will not be funds for the deployment of primary health care services.

"As long as you, the educators of health personnel, continue to train students mainly within the four walls of a hospital, our graduates will not be in a position to function efficiently in the community.

"As long as all medical faculties in South Africa want to buy immediately all the newest equipment, and they are not prepared to make agreements to share equipment with other faculties, or even the private sector, there will continue to be communities deprived of basic health services." — Sapa.

HOUSE OF ASSEMBLY

QUESTIONS

† Indicates translated version.

For written reply:

General Affairs:

Hospitals: integrated wards

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

(1) Whether any wards in hospitals administered by the State are integrated; if so, how many in each specified hospital; if not; why not;

(2) whether her Department intends to desegregate wards in State hospitals; if not; why not; if so, when;

(3) whether any studies have been carried out into the cost implications of desegregating wards in State hospitals; if not, why not; if so, (a) when, (b) by whom and (c) what were the findings;

(4) whether any wards in State hospitals are underutilised; if so, (a) in which specified hospitals and (b) to what extent;

(5) whether any wards in State hospitals are overcrowded; if so, (a) in which specified hospitals and (b) to what extent?

B280E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes,

— Transvaal:
Johannesburg Hospital, five wards;
H F Verwoerd Hospital, Pretoria, one ward;
Boksburg-Benoni Hospital, one ward;
Pietersburg Hospital, one ward;
Klerksdorp Hospital, one ward;
Rob Ferreira Hospital, Nelspruit, one ward.

— Cape Province:
In the Cape Province intensive care and high care units are integrated as special facilities such as, for example, radiotherapy, dialysis units, infertility clinics, resuscitation units, theatres and recovery rooms, physiotherapy and occupational therapy and radio diagnostic units in the following hospitals:
Tygerberg, Groote Schuur, Red Cross, George, Mossel Bay, Kimberley, Beaufort West, Frere, Bedford, Vryburg and Upington hospitals.

— Orange Free State:
In the Orange Free State no wards are integrated.

— Natal:
It is extremely difficult to give the number of wards involved. The following information is however supplied.
All the wards of the following hospitals under the control of the NPA are totally integrated:
Wentworth
King George
Clairwood
Stanger
Northdale
Emmaus
King Edward
R K Khan
Osindisweni
Murchison
Greytown Provincial Hospital.
All other wards where specialised services are provided and which are not available elsewhere are integrated, eg Renal unit and Oncology at Addington Hospital,

(2) in view of developments in respect of the Reservations of Separate Amenities Act 1953 (Act No 49 of 1953), this aspect is at present receiving attention.

(3) No, no studies have been undertaken because it was not deemed necessary.

(4) Yes,
(a) and (b) Statistical information is based on the number of approved beds and not for individual wards. The following hospitals reflect an average percentage bed occupancy of less than sixty per cent for the 1988/89 financial year:

Transvaal:

Hospital	*Average percentage bed occupancy**
Amajuba Memorial (Volksrust)	45,5% (W)
Barberton	46,8% (W)
	32,0% (I)
	48,3% (B)
Bethal	37,9% (W)
	59,5% (B)
	4,1% (I)
	2,4% (C)
Boksburg-Benoni	28,6% (I)
Carolina	43,3% (W)
Christiana	35,9% (W)
Dr A G Visser (Heidelberg)	28,1% (I)
Ellisras	47,4% (W)
Ermelo	51,3% (W)
F H Odendaal (Nylstroom)	50,6% (B)
J D Verster (Koster)	46,1% (W)
Laudium	30,2% (I)
Lenasia**	2,2% (I)
Klerksdorp	57,1% (W)
	53,7% (I)
Lydenburg	51,2% (W)
Middelburg	25,3% (C)
	20,2% (I)
Nigel	47,1% (W)
	47,7% (C)
	58,3% (B)
Nic Bodenstein	56,9% (W)
	58,9%(B)
Leratong (Krugersdorp)	15,0% (I)
Paul Kruger Memorial (Rustenburg)	40,3% (I)
	57,2% (W)
Pietersburg	23,1% (I)
	53,7% (W)
Piet Retief	41,0% (W)
	32,3% (I)
Rietfontein	36,2% (W)
	16,6% (I)
Rob Ferreira (Nelspruit)	49,6% (W)
Sabie	43,6% (W)
	58,8% (B)
Schweizer-Reneke	32,1% (W)
	0,6% (I)
Standerton	38,0% (C)
	50,1% (W)
	10,3% (I)
Sebokeng	4,8% (I)
Far East Rand (Black), Springs	15,3% (I)
Westfort (Pretoria)	59,5% (B)
Witbank	56,2% (W)
Witrand (Potchefstroom)	38,1% (B)
Zeerust	47,1% (W)
	39,5% (I)

* W — White; C — Coloured; I — Indian; B — Black.

** Lenasia Hospital was commissioned during January 1989.

Orange Free State:

Hospital	*Occupancy*	
	White Wards	*Non-White Wards*
Universitas, Bloemfontein	57,7	—
National, Bloemfontein	52,43	—
Bethlehem	54,16	—
Sasolburg	50,18	—
Ficksburg	22,18	85,18
Frankfort	32,01	66,78
Harrismith	17,8	80,1
Ladybrand	18,61	51,8
Reitz	20,4	65,4
Senekal	26,7	63,2
Smithfield	30,4	51,6
Vrede	22,7	62,9
Winburg	24,3	77,9
Zastron	29,6	—

Cape Province:

Hospital	*% occupancy*
Beaufort West	54,90
Bredasdorp	57,43
Caledon	52,90
Garies	45,34
Karl Bremer (Bellville)	48,96
Ladismith	39,99
Malmesbury	54,87
Porterville	46,69
City (Green Point)	43,16
Eaton Rehabilitation	49,73
Lady Michaelis	43,79
Princess Alice	54,71
Volks, Oranjezicht	38,64
Avalon	39,04
Prieska	27,98
Victoria West	42,26

Cradock	55,21
Graaff-Reinet	49,08
King William's Town	51,60
Middelburg	55,42
Provincial, Port Elizabeth	55,72
Steynsburg	53,74
Walvis Bay	55,41

Natal:

Hospital	*% occupancy*
Ixopo (White)	27
Dundee (all races)	30
Escourt (White and Indian)	30
Kokstad (White and Coloured)	14
Empangeni (all races)	57c
Eshowe (White)	24
Greytown (White)	32
Greytown Provincial	45
Ladysmith (White)	54
Newcastle (all races)	50
Port Shepstone (White)	50
Harding (White)	2
Matatiele (White and Coloured)	8
Utrecht (all races)	54
Vryheid (White)	37
Wentworth (all races)	59

(5) Yes, certain hospitals are over crowded (a) and (b) Statistical information for hospitals is based on the number of approved beds and not for individual wards. The following hospitals reflect on average percentage bed occupancy in excess of ninety per cent for the 1988/89 financial year:

Transvaal:

Hospital	*Average percentage bed occupancy*
Amajuba Memorial (Volksrust)	102,0%(B)
Baragwanath (Soweto)	97,0%(B)
Boksburg-Benoni	91,3%(B)
	154,9%(C)
Christiana	127,3%(B)
Dr A G Visser (Heidelberg)	107,0%(B)
Ermelo	95,4%(B)
Ga-Rankuwa (Pretoria)	97,6%(B)
Itshelejuba (Pongola)	129,9%(B)
J D Verster (Koster)	147,8%(B)
Natalspruit (Alberton)	99,6%(B)
Nic Bodenstein (Wolmaranstad)	97,6%(C)
Paul Kruger Memorial (Rustenburg)	121,5%(B)
Rob Ferreira (Nelspruit)	93,4%(B)
Sabie	146,8%(C)
Schweizer-Reneke	97,1%(B)
Far East Rand (Springs)	98,8%(B)
Weskoppies (Pretoria)	137,8%(B)

Orange Free State:

Hospital	*Non-White*
Phekolong, Bethlehem	143,29%
Boitumelo, Kroonstad	101,85%
Welkom (Non-White ward)	187,76%
Zastron (Non-White ward)	115,2%

Cape Province:

Hospital	*% occupancy*
Kakamas	92,33
Reivilo	94,48
Bedford	105,41
Livingstone, Port Elizabeth	93,81
Oudtshoorn	93,20
Ceres	101,90
Conradie, Pinelands	90,19
Somerset West	109,58
Vredendal	93,31
Red Cross Hospital	104,73

Natal:

Hospital	*Beds*	*% occupancy*
Bruntville CHC	16	138
Ixopo (Non-White)	160	113
Kokstad (Non-White)	170	93
King Edward (all races)	1 913	96
Ladysmith (Non-White)	512	92

Patient/doctor/nurse ratio

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

What was the (a) patient/doctor and (b) patient/nurse ratio in 1989 at each specified hospital falling under the control of the provincial administrations?

B551E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) Patient (Private patients excluded)/Doctor (Full time doctors only) and

(b) Patient (Private patients included)/Nurse (All nurses) ratio as on 31 December 1989 at each specified hospital falling under the control of the provincial administrations?

Natal Provincial Administration

Hospital	*(a) No. of Patients per doctor*	*(b) No. of Patients per nurse*
Addington	13,48	1,00
Clairwood	53,77	1,97
Dundee	35,11	1,58
East Griqualand and Usher Memorial	27,50	1,69
Eshowe	37,64	2,06
Estcourt	37,87	1,67
G J Crooks	35,67	2,21
Grey's	9,46	0,66
Greytown	42,85	2,36
Hillcrest	98,00	1,51
King Edward VIII	14,83	1,83
Ladysmith	33,84	2,20
Empangeni	10,50	0,92
Newcastle	15,80	0,97
Northdale	20,13	1,61
Port Shepstone	37,41	2,27
R K Khan	22,44	2,26
Stanger	42,23	2,76
Taylor Bequest	28,75	1,03
Utrecht	29,00	1,91
Vryheid	31,87	2,00
Wentworth	9,11	0,68
Christ the King	55,25	1,93
St Andrews	44,75	1,37
Midlands		
King George V		
Emmaus	Not available at present	
Osindisweni		
Murchison		
St Appolonaris		

Orange Free State	(a)	(b)
Universitas/National	* 2,63	0,31
Pelonomi/		0,83
Oranje	72,00	1,96
Voortrekker/		0,82
Boitumelo	*15,97	1,13
Bethlehem/		0,57
Phekolong	*25,39	1,63
Odendaalsrus	—	1,23
Sasolburg	—	0,50
Virginia	—	1,29
Welkom	17,36	1,00
Bothaville	—	1,06
Clocolan	—	2,52
Ficksburg	—	1,75
Frankfort	—	1,14
Harrismith	—	1,02
Heilbron	—	1,52
Hopetown	—	1,77
Jagersfontein	—	1,46
Ladybrand	—	0,53
Parys	—	1,11
Reitz	—	1,25
Senekal	—	2,26
Smithfield	—	1,16
Vrede	—	1,16
Winburg	—	1,14
Zastron	—	1,64

• = Doctors serve group of hospital.
— = No full time doctors employed.

Cape Provincial Administration	(a)	(b)
Barkly West	—	1,19
Colesberg	—	1,33
De Aar	72,00	0,98
Douglas	—	1,39
Hartswater	—	1,95
Kakamas	—	0,95
Kimberley	8,00	0,78
Kuruman	—	1,31
Noupoort	—	0,89
Postmasburg	—	1,34
Prieska	—	0,86
Reivilo	—	1,37
Upington	120,00	1,10
Vryburg	—	1,18
Aliwal North	—	0,97
Barkly East	—	1,18
Bedford	—	1,22
Burgersdorp	—	1,56
Cathcart	—	0,87
Cradock	97,00	0,96
Dora Nginza	6,14	0,34
Elliot	—	1,42
Fort Beaufort	—	1,00
Graaff-Reinet	—	0,60
Grahamstown	—	0,98
Humansdorp	—	1,00
King William's Town	6,71	0,38
Livingstone	6,86	0,77

Qhoweng (Reddersburg)		5
Rammulotsi (Viljoenskroon)		7

(b) (i) *Town Committees* — *Wards*

Ratanang (Jacobsdal)	6
Rweleleyathunya (Rouxville)	6
Seretse (Boshof)	6
Thembalihle (Vrede)	7
Tikwana (Hoofstad)	6
Thlolong (Kestell)	4
Tswaraganang (Dealesville)	6
Tumahole (Parys)	8
Zamani (Memel)	4
TOTAL	311

(ii) *City Councils* — *Wards*

Bohlokong (Bethlehem)	12
Mangaung (Bloemfontein)	17
Maokeng (Kroonstad)	15
Thabong (Welkom)	13
TOTAL	57

Town Councils — *Wards*

Kutlwanong (Odendaalsrus)	9
Manyatseng (Ladybrand)	7
Meloding (Virginia)	7
Petsana (Reitz)	5
Phahameng (Bultfontein)	6
Phiritona (Heilbron)	7
Phomolong (Hennenman)	6
Qibing (Wepener)	6
TOTAL	53

Local Authority Committees — *Wards*

Thapelang (Vanstadensrus)	5
Tshepong (Verkeerdevlei)	5
TOTAL	10
GRAND TOTAL	**431**

Cape Province

(a) (i) 77

(ii) 15

(b) Local Authorities — Number of Wards

Town Committees:

I *Western Cape*

1.	Bongolethu (Oudtshoorn)	8
2.	Kruispad (Cape Town)	1
3.	KayaMandi (Stellenbosch)	7
4.	Kwanonqaba (Mossel Bay)	7
5.	Masinyusane (Victoria West)	5
6.	Mbekweni (Paarl)	7
7.	Mfuleni (Kuils River)	7
8.	Nduli (Ceres)	5
9.	Nqubela (Robertson)	7
10.	Sidesaviwa (Beaufort West)	7
11.	Thembalethu (George)	9
12.	Zolani (Ashton)	7
13.	Zweletemba (Worcester)	7
14.	Zwelihle (Hermanus)	5

II *Northern Cape*

1.	Boichoko (Postmasburg)	6
2.	Boipelo (Reivilo)	6
3.	Bongani (Douglas)	6
4.	Ditloung (Olifantshoek)	6
5.	Ethembeni (Prieska)	6
6.	Huhudi (Vryburg)	8
7.	Ikhutseng (Warrenton)	6
8.	Kutlwano (Windsorton)	1
9.	Kuyasa (Colesberg)	8
10.	KwaZamuxolo (Noupoort)	7
11.	Lukhanyisweni (Philipstown)	5
12.	Mataleng (Barkly West)	6
13.	Matlomola (Griekwastad)	6
14.	Motswedimosa (Ritchie)	1
15.	Mziwabantu (Britstown)	5
16.	Nompumelelo (Hanover)	6
17.	Sabelo (Richmond)	1
18.	Thembinkosi (Petrusville)	6
19.	Tidimalo (Delportshoop)	6
20.	Tlhakalatlou (Daniëlskuil)	6
21.	Valspan (Jan Kempdorp)	6

III *Eastern Cape*

1.	Bhongweni (Cookhouse)	1
2.	Bontrug (Kirkwood)	1
3.	Cumakala (Stutterheim)	1
4.	Dukathole (Aliwal North)	1
5.	Dyoki (Ugie)	1
6.	Ginsberg (King William's Town)	1
7.	Gompo Town (East London)	8
8.	Katikati (Cathcart)	6
9.	Khanyiso (Pearston)	1
10.	Khayamnandi (Steynsburg)	6
11.	Khwesinaledi (Lady Grey)	1
12.	KwaNojoli (Somerset East)	1
13.	KwaNomzamo (Humansdorp)	1
14.	Kwanonqubela (Alexandria)	1
15.	KwaNonzame (Middelburg, Cape)	1
16.	Kwanonzwakazi (Alicedale)	1

17.	Kwatinidubu (Fort Beaufort)	1
18.	KwaZamukucinga (Jansenville)	1
19.	Kwazenzele (Paterson)	1
20.	Lingelethu (Adelaide)	1
21.	Luxolweni (Hofmeyer)	1
22.	Masakhane (Jamestown)	1
23.	Masakhe (Sterkstroom)	1
24.	Masibambane (Elliot)	1
25.	Mavuya (Indwe)	1
26.	Mlungisi (Queenstown)	8
27.	Mzamomhle (Burgersdorp)	1
28.	Nkululeko (Barkly East)	1
29.	Nolukhanyo (Bathurst)	1
30.	Nomonde (Molteno)	6
31.	Nozizwe (Venterstad)	1
32.	Nyarha (Bedford)	1
33.	Motherwell (Port Elizabeth)	8
34.	Qumrha (Komga)	1
35.	Sinakho (Dordrecht)	1
36.	Sonwabile (Maclear)	1
37.	Thembalesizwe (Aberdeen)	1
38.	Umasizakhe (Graaff-Reinet)	1
39.	Umzamomhle (Hankey)	1
40.	Vuyolwethu (Steytlerville)	1
41.	Wongalethu (Klipplaat)	1
42.	Zola (Tarkastad)	1

Other Black Local Authorities

I *City Councils*

Western Cape	:	—
Northern Cape	: Galeshewe (Kimberley)	12
Eastern Cape	: Ibhayi (Port Elizabeth)	21
	: Kwanobuhle (Uitenhage)	16
	: Rini (Grahamstown)	9

II *Town Councils*

Western Cape	: Ikapa (Cape Town)	20
	: Kuisebmond (Walvis Bay)	8
	: Lingelethu West (Cape Town)	1
Northern Cape	: Paballelo (Upington)	6
	: Nonzwakazi (De Aar)	6
Eastern Cape	: Lingelihle (Cradock)	1

III *Local Authority Committees*

Western Cape	: Lwandle (Strand)	1
Northern Cape	:	—
Eastern Cape	: Jeffreys Bay	1
	: Kareedouw	1
	: Keiweg	1
	: Rhodes	1

MBOD: post of director

269. Mr P J PAULUS asked the Minister of National Health and Population Development:†

(1) Whether the post of director at the Medical Bureau for Occupational Diseases has been filled; if so, by whom; if not, why not;

(2) (a) what remuneration package is offered for this post and (b) how does this remuneration compare with that for a similar post in the private sector?

B705E

Hansard 27/4/90

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No, a candidate has been offered an appointment but she is still negotiating the service benefits package with the Department of National Health and Population Development and the Commission for Administration;

(2) (a) the package for remuneration is that of a managerial post in the Public Service at the level of Director with inter alia a salary of R74 319 per annum (fixed) plus participation in the motor vehicle financing scheme for senior officials,

(b) the package for remuneration is regarded as fairly market-related to the package for remuneration of a comparable post in the private sector.

Qhoweng (Reddersburg)		5
Rammulotsi (Viljoenskroon)		7
(b) (i)	*Town Committees*	*Wards*
	Ratanang (Jacobsdal)	6
	Rweleleyathunya (Rouxville)	6
	Seretse (Boshof)	6
	Thembalihle (Vrede)	7
	Tikwana (Hoofstad)	6
	Thlolong (Kestell)	4
	Tswaraganang (Dealesville)	6
	Tumahole (Parys)	8
	Zamani (Memel)	4
	TOTAL	311
(ii)	*City Councils*	*Wards*
	Bohlokong (Bethlehem)	12
	Mangaung (Bloemfontein)	17
	Maokeng (Kroonstad)	15
	Thabong (Welkom)	13
	TOTAL	57
	Town Councils	*Wards*
	Kutlwanong (Odendaalsrus)	9
	Manyatseng (Ladybrand)	7
	Meloding (Virginia)	7
	Petsana (Reitz)	5
	Phahameng (Bultfontein)	6
	Phiritona (Heilbron)	7
	Phomolong (Hennenman)	6
	Qibing (Wepener)	6
	TOTAL	53
	Local Authority Committees	*Wards*
	Thapelang (Vanstadensrus)	5
	Tshepong (Verkeerdevlei)	5
	TOTAL	10
	GRAND TOTAL	431

Cape Province

(a) (i) 77

(ii) 15

(b) Local Authorities	Number of Wards
Town Committees:	
I *Western Cape*	
1. Bongolethu (Oudtshoorn)	8
2. Kruispad (Cape Town)	1
3. KayaMandi (Stellenbosch)	7
4. Kwanonqaba (Mossel Bay)	7
5. Masinyusane (Victoria West)	5
6. Mbekweni (Paarl)	7
7. Mfuleni (Kuils River)	7
8. Nduli (Ceres)	5
9. Nqubela (Robertson)	7
10. Sidesaviwa (Beaufort West)	7
11. Thembalethu (George)	9
12. Zolani (Ashton)	7
13. Zweletemba (Worcester)	7
14. Zwelihle (Hermanus)	5
II *Northern Cape*	
1. Boichoko (Postmasburg)	6
2. Boipelo (Reivilo)	6
3. Bongani (Douglas)	6
4. Ditloung (Olifantshoek)	6
5. Ethembeni (Prieska)	6
6. Huhudi (Vryburg)	8
7. Ikhutseng (Warrenton)	6
8. Kutlwano (Windsorton)	1
9. Kuyasa (Colesberg)	8
10. KwaZamuxolo (Noupoort)	7
11. Lukhanyisweni (Philipstown)	5
12. Mataleng (Barkly West)	6
13. Matlomola (Griekwastad)	6
14. Motswedimosa (Ritchie)	1
15. Mziwabantu (Britstown)	5
16. Nompumelelo (Hanover)	6
17. Sabelo (Richmond)	1
18. Thembinkosi (Petrusville)	6
19. Tidimalo (Delportshoop)	6
20. Tlhakalatlou (Daniëlskuil)	6
21. Valspan (Jan Kempdorp)	6
III *Eastern Cape*	
1. Bhongweni (Cookhouse)	1
2. Bontrug (Kirkwood)	1
3. Cumakala (Stutterheim)	1
4. Dukathole (Aliwal North)	1
5. Dyoki (Ugie)	1
6. Ginsberg (King William's Town)	1
7. Gompo Town (East London)	8
8. Katikati (Cathcart)	6
9. Khanyiso (Pearston)	1
10. Khayamnandi (Steynsburg)	6
11. Khwesinaledi (Lady Grey)	1
12. KwaNojoli (Somerset East)	1
13. KwaNomzamo (Humansdorp)	1
14. Kwanonqubela (Alexandria)	1
15. KwaNonzame (Middelburg, Cape)	1
16. Kwanonzwakazi (Alicedale)	1

17.	Kwatinidubu (Fort Beaufort)	1
18.	KwaZamukucinga (Jansenville)	1
19.	Kwazenzele (Paterson)	1
20.	Lingelethu (Adelaide)	1
21.	Luxolweni (Hofmeyer)	1
22.	Masakhane (Jamestown)	1
23.	Masakhe (Sterkstroom)	1
24.	Masibambane (Elliot)	1
25.	Mavuya (Indwe)	1
26.	Mlungisi (Queenstown)	8
27.	Mzamomhle (Burgersdorp)	1
28.	Nkululeko (Barkly East)	1
29.	Nolukhanyo (Bathurst)	1
30.	Nomonde (Molteno)	6
31.	Nozizwe (Venterstad)	1
32.	Nyarha (Bedford)	1
33.	Motherwell (Port Elizabeth)	8
34.	Qumrha (Komga)	1
35.	Sinakho (Dordrecht)	1
36.	Sonwabile (Maclear)	1
37.	Thembalesizwe (Aberdeen)	1
38.	Umasizakhe (Graaff-Reinet)	1
39.	Umzamomhle (Hankey)	1
40.	Vuyolwethu (Steytlerville)	1
41.	Wongalethu (Klipplaat)	1
42.	Zola (Tarkastad)	1

Other Black Local Authorities

I	*City Councils*		
	Western Cape	:	—
	Northern Cape	: Galeshewe (Kimberley)	12
	Eastern Cape	: Ibhayi (Port Elizabeth)	21
		: Kwanobuhle (Uitenhage)	16
		: Rini (Grahamstown)	9
II	*Town Councils*		
	Western Cape	: Ikapa (Cape Town)	20
		: Kuisebmond (Walvis Bay)	8
		: Lingelethu West (Cape Town)	1
	Northern Cape	: Paballelo (Upington)	6
		: Nonzwakazi (De Aar)	6
	Eastern Cape	: Lingelihle (Cradock)	1
III	*Local Authority Committees*		
	Western Cape	: Lwandle (Strand)	1
	Northern Cape	:	—
	Eastern Cape	: Jeffreys Bay	1
		: Kareedouw	1
		: Keiweg	1
		: Rhodes	1

MBOD: post of director

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(1) Whether the post of director at the Medical Bureau for Occupational Diseases has been filled; if so, by whom; if not, why not;

(2) (a) what remuneration package is offered for this post and (b) how does this remuneration compare with that for a similar post in the private sector?

B705E

Hansard 27/4/90

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) No, a candidate has been offered an appointment but she is still negotiating the service benefits package with the Department of National Health and Population Development and the Commission for Administration;

(2) (a) the package for remuneration is that of a managerial post in the Public Service at the level of Director with inter alia a salary of R74 319 per annum (fixed) plus participation in the motor vehicle financing scheme for senior officials,

(b) the package for remuneration is regarded as fairly market-related to the package for remuneration of a comparable post in the private sector.

What hospitals think

Hospital superintendents and managers hold sharply divided views on privatisation and a national health system. Some diehards remain as racist as ever.

These were the findings of a survey by Pim Goldby Management Consultants on the challenges facing SA hospitals. The survey was conducted late last year and the results were released last week. The questionnaire was sent to the top people in more than 700 hospitals in the private and public sectors. About 30% replied. Some respondents defied the ban on taking part in surveys that some provincial administrations maintain.

The survey pointed out wide discrepancies in hospital occupancy. No less than 13% reported an occupancy rate of more than 100%, which meant that some patients were sleeping on the floor. In Natal, 28% reported an overflow of patients. Moreover, the survey was compiled before the height of the current violence. On the other hand, 10% of the hospitals surveyed reported occupancy rates of less than 50%, well under the 60% break-even point in the private sector.

"Don't sell Bara"

The survey results included a series of comments and privatisation proved to be a most divisive issue. Predictably, 75% of private sector hospital chiefs felt that privatisation would lead to a cheaper and more efficient health care system, though a surprisingly high 23% disagreed.

In the provincial sector, the strongest opposition came from superintendents of hospitals with more than 700 beds — those chaotic public institutions such as Baragwanath in Soweto and King Edward in Durban that could benefit the most from private sector discipline. Of these, 53% felt privatisation would not lead to a less expensive and more efficient system.

"Frankly, it's difficult to imagine anyone wanting to buy Baragwanath," says Pim Goldby's Greg Candy. "But it could certainly be commercialised and certain services could be contracted to the private sector."

Comments reflect the public/private polarisation: "A system of national health is the only fair system," says the head of a state hospital in a large city. A manager from the private sector states: "Privatisation would give better management in terms of control, innovations, asset utilisation, cost savings and high standards." But another private administrator says "privatisation of health care should be preceded by the establishment of national health insurance for the whole country."

Racism is still firmly rooted at many hospitals; a diehard proportion of administrators oppose nonracialism, though desegregating hospitals is the most obvious way to rationalise. Fully 17% believe that it would have a detrimental affect on their services and 21% felt that it would actually hurt finances, even though it would obviously increase occupancy rates in white hospitals.

The good news is that a majority of the public sector chiefs, 51%, agree that desegregation would have a positive effect on their finances. One head of a hospital in a medium-size city says: "Duplication of services — separate black, white and Asian/coloured hospitals — costs three times as much. Furthermore, nurses have become stereotyped and do not learn cross-cultural nursing."

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'All SA's academic hospitals hit by debilitating malaise'

A report by two academic doctors on the plight of hospitals has lifted the veil of silence authorities have tended to draw over the crisis threatening the SA health system, writes LESLEY LAMBERT from Cape Town.

THE report on the hospitals crisis published in the latest edition of the SA Medical Journal was, according to its Groote Schuur authors, written after the recent simultaneous resignation of their counterparts at Pretoria University.

It is not by coincidence that the report follows other signals of the plight of academic hospitals — the recent strike by non-medical hospital workers in the western Cape — and announcements of reductions in the annual provincial health budgets, in spite of the dire need for additional funding.

Unaware

As the authors — Groote Schuur cardiothoracic unit head Prof John Odell and cardiology unit head Prof Pat Commerford — say: "Pretoria is not alone in its difficulties, which are symptomatic of a wider malaise affecting all our academic hospitals."

"The authorities responsible for funding these hospitals seem to be unaware that they cannot have their cake and eat it; that they cannot proudly claim that SA's health facilities are among the best in the world, while at the same time denying the necessary finance to maintain these high standards."

The report focuses largely on the deficiency of facilities in Groote Schuur Hospital's heart unit. It expresses concern at the widespread belief that cardiology and cardiothoracic surgery are highly sophisticated and too expensive for the SA health care system when the reality is that at least 25% of all deaths are primarily cardiovascular, while heart disease remains a highly important cause of disability in all South Africans.

Odell and Commerford say equipment at Groote Schuur — the hospital responsible for the first heart transplant — has deteriorated to the bare minimum acceptable state and that any further deterioration will lead to a loss of irreplaceable clinical skills.

Estimates are that the hospital would need an additional R2,5m to bring cardiology and cardiothoracic units alone to satisfactory standards. Doctors admit this request is impractical in current economic and political conditions.

But, Odell says, there is one really pressing need: for a new heart/lung machine, at a cost of R213 000. Of the two the unit has, one is no longer functioning properly and, unless replaced, will result in a 50% reduction in open heart surgery.

The report states that apart from periodic maintenance and occasional replacement of malfunctioning equipment, minimal investment has been made in sophisticated modern investigation equipment.

Instead, existing equipment has been allowed to deteriorate and replacements have been deferred on the understanding that deficiencies would be rectified during the move to the new hospital building.

Essential items of equipment "condemned" several years ago have not been replaced and are in daily use and, in occasional instances, patient safety has been compromised by faulty equipment.

The authors say the situation is serious and prospects for improvement are poor. Cardiology and Cardiothoracic Surgery will be among the last departments to move to the new hospital and, given the current shortage of funds, it is unlikely they will be provided with the sort of equipment needed for the units to function efficiently.

Another major problem is staff. Medical, nursing and technological staff have become increasingly dissatisfied and disillusioned at being denied the opportunity and the reward of offering their patients optimal care using up-to-date equipment.

The report says privatisation becomes increasingly attractive to staff expected to fight protracted bureaucratic battles, which may last several years, simply to replace an obsolete piece of equipment or to obtain access to a new form of technology that will improve their diagnostic or therapeutic abilities. This carries with it the threat of increased health and hospital costs for the man-in-the-street.

Provincial

Odell has had discussions with Groote Schuur superintendent Dr Jocelyn Kane-Berman and CPA Director of Hospital Services Dr George Watermeyer, who have expressed sympathy and promised assistance within their limits.

But, he is aware that funding problems cannot be solved at a provincial level and unless government allocates additional funds, conditions will continue to deteriorate to the point where other academic doctors may decide to follow their Pretoria University colleagues.

Unofficial HIV figures top 55 000 — Minister

Political Staff

CAPE TOWN — A total of 3 431 South Africans had been reported HIV-positive by March 9, Health Mininster Dr Rina Venter said yesterday.

However, this figure was based only on voluntary anonymous reports received from diagnostic centres.

Venter said the best available estimates based on various data sources suggested that the number of people infected with HIV in SA at the end of last year was about 55 000.

The World Health Organisation has estimated that almost 500 000 people in SA could be infected with HIV by the end of next year.

Venter said in reply to a question from Francois Pauw (CP, nominated) that more than 90% of transmissions of HIV infection took place by sexual contact or were transmitted from the mother to the unborn child.

Less than 10% of HIV infection was preventable through medical technology. "This is already taken care of by rendering a blood transfusion service as safe as possible."

Venter said various disciplines of the health services were already involved in awareness and knowledge dissemination campaigns.

"Motivation towards safer sexual practices is mainly done in small groups or on an individual basis."

To this end the department had established AIDS training and information centres in Cape Town, Port Elizabeth, Durban, Bloemfontein and Johannesburg.

"These centres are to act as sources of information to assist trainers and counsellors to motivate local communities and attain community involvement and participation in anti-AIDS campaigns," she said.

Bickering hindering rural health, conference told

Star 30/4/90 (85)

Own Correspondent

Bickering between pharmacists and doctors is affecting the implementation of community health services in South Africa.

Stamping grounds were being defended, said Dr Stephen Louw from the University of Cape Town during a panel discussion on the impact of utilised research findings on community health, held at the Human Sciences Research Council (HSRC) in Pretoria last week.

In response to a question from the floor on whether the bickering was ethical he replied "one should use the resources on hand to help as many people as possible in a community".

'Egotistical' cancer

One delegate said he believed the implementation of medical research was strongly restrained by the egos involved.

"This is an inherent cancer which has crept into health care.

"It is a global phenomenon," replied Dr Derek Yach from the Medical Research Council.

Another said one of the gravest problems of implementing community health in rural areas was that the contribution which could be made by qualified community health nurses was often overlooked.

Dr Yach replied that the implementation of these services hinged on a multidisciplinary team approach.

He said a paradox existed in community health research.

The Department of National Health and Population Development was gradually shifting the health care em phasis to the poorer communities.

Much of the research was handled by universities, which had a lot to lose in terms of labratory facilities and equipment through budget cuts.

Dr Louw said universities were already suffering from financial cutbacks imposed during the past two years and many posts were now vacant.

Another delegate said a balance be tween the training of "top people" and the rendering of community health services was essential.

During another panel discussion on research and environmental conservation strategies Professor John Butler-Adam from the University of Durban-Westville said the Government had no fixed conservation policy. Neither did most conservation groups, which meant implementing research findings was extremely difficult.

He said conflicts of interests occurred between conservationists, Government officials and developers using South African beaches. These differences were being investigated.

Health care will be major component of a changed SA, says medical academic

OWN CORRESPONDENT

CAPE TOWN — South Africa would be better off with a single democratic public health service combined with a smaller private medical sector than its present bloated, fragmented and "grossly underfunded" system, a leading medical academic says.

Professor Solly Benatar, head of the University of Cape Town's department of medicine, writing on a unitary health service for South Africa in the South African Medical Journal, says the present 14 ministries of health oversee "an irrational mix of private and public health facilities, which is damaging to the economy and to health care".

Medicine and health care services here are characterised by "a history of inadequate planning, control and management".

The present system is "maldistributed, poorly funded and co-ordinated, fragmented and duplicated, discriminatory on a racial basis, hospital-based and supported by very poorly developed ancillary services".

All this is underpinned by a medical education system that has not been adequately moulded to cater for the population's diverse needs.

The population is expected to double over the next 25 to 30 years with a continuing rapid influx into urban areas.

However, expenditure on health, now slightly more than 5 percent of the gross national product, has increased only slowly. The country's stagnating economy has contributed to a "grossly underfunded health care service".

South Africa's other successes — in comparison with the rest of Africa — have been totally eclipsed by the effects of its racially discriminatory political and social policies.

These had "stultified and degraded the lives of millions, engrained hatred, cynicism and despair into many, silenced or driven to other countries talented citizens and isolated the country internationally".

Thus the elimination of apartheid would be the first and most important step towards reducing the disparities between different groups in this country.

Under these circumstances the actual form health care should take will have to be carefully determined.

Privatisation was not necessarily the answer. The economic behaviour of the health care market did not correspond to the idealised rules of the free market.

Researchers had suggested serious ethical criticisms of "for-profit" health care. These included problems of access to care; treatment of health care as a commodity to be bought and sold; and the threat of undue influence exerted by the economic power of the medical industrial complex.

In South Africa in the mid-1980s about 46 percent of all medical practitioners were employed in the private sector, he points out. This sector accounted for about 44 percent of all health care expenditure yet provided only about 13 percent of hospital beds.

"The crisis in South African medicine reflects not only the crisis facing medicine in the Western world but also the crisis of political legitimacy in this country and the problem of delivering modern health care to a population that is growing rapidly and becoming urbanised," he says.

Demands for more equity, and more appropriate use of resources, were taking place against a background of wide disparities in health and economic life.

The central question was, whose values would count in shaping our health care system, and indeed our society, as we moved into the future?

The contributions that the medical profession can make to a changing South Africa will be to broaden medical education and make it more relevant to the needs of our communities without sacrificing its scientific base; to develop and implement the concept of community-based medicine and health care teams, especially in rural areas; and to develop means of allocating and utilising resources justly and optimally within a well co-ordinated, planned and controlled health care service.

The likelihood of achieving a satisfactory health service is greatest "within a society moving rapidly towards democracy, with a vigorous and growing economy and a strong social commitment expressed medically in the form of a unitary health service working in collaboration with a smaller private medical sector that complements rather than detracts from the public health service".

The MINISTER OF HOUSING:

No.

Section 6 of the Prevention of Illegal Squatting Act 1951, Act No 52 of 1951 as amended, provides that a local authority can expropriate land or take the right to use land temporarily for the purpose of declaring the land a transit area. In the case of the squatter settlements in Lenasia, accurate property descriptions of all the land on which squatting takes place have been obtained to enable the Administration to approach the relevant local authority to implement the provisions of the said Act. This issue is presently receiving the urgent attention of the Administration.

(a) Falls away.

(b) Falls away.

(c) Falls away.

Mr D K PADIACHEY: Mr Chairman, arising out of the hon the Minister's reply, how long are we going to carry on with this problem? When is it going to be addressed?

The MINISTER: Mr Chairman, the hon member lives in that area. He will see movement there if he watches carefully. [Interjections.]

Mr D K PADIACHEY: Mr Chairman, arising out of the hon the Minister's reply, is he not again doing a somersault? There is no movement taking place there and nothing has been done.

The MINISTER: Mr Chairman, the questions have been answered adequately. If anybody understands what I have just read, they will see that there is a message in that. One cannot take a bulldozer and throw people out. It is a very serious matter. I think that we should attend to this with a sense of maturity. That is all it is. If somebody has made promises about cleaning up that area, he must live with that.

I, as Minister, can only go about this using the machinery at my disposal and execute this task in a responsible manner, and I hope in due course evidence will be forthcoming to satisfy our hon colleague.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the hon the Minister's answers, is he willing to utilise funds of the Housing Board or the Administration to transport these squatters out of Lenasia?

The MINISTER: Mr Chairman, that matter has not come up for consideration at the moment.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, further arising out of the answer given by the hon the Minister, namely that that matter has not come up for consideration, is he changing his story today in respect of an answer given on a previous occasion, namely that R1 000 would be provided by the House of Delegates?

The MINISTER: Mr Chairman, my reply states that we are taking steps to make that area an area designated in terms of the law. That is the first step.

Mr D K PADIACHEY: The first step since when?

The MINISTER: I am not asking that the people be shifted from there.

The LEADER OF THE OFFICIAL OPPOSITION: You said that! [Interjections.]

The CHAIRMAN OF THE HOUSE: Order! The hon the Minister is on his feet.

The MINISTER: There is my answer, Mr Chairman, and, as I said, movements are being proposed and one will have to go step by step. This will be a transit camp, and if the time comes when people can be provided with alternative accommodation, we will then look into the matter.

New questions:

*1. Leader of the Official Opposition—Housing. [Question standing over.]

Allocation of properties at home of MP

*2. The LEADER OF THE OFFICIAL OPPOSITION asked the Minister of Housing:

(1) Whether any official of his Department attended to the allocation of properties at the home of a member of Parliament; if so, what is the name of this member of Parliament;

(2) whether the allocation policy and/or procedures in respect of the allocation of properties in Richards Bay were altered by the regional office of his Department; if so, (a) at whose request, (b) in what manner, (c) when and (d) why? D149E

The MINISTER OF HOUSING:

(1) No.

(2) No.

(a) Falls away.

(b) Falls away.

(c) Falls away.

(d) Falls away.

Budget of Department

*3. Mr M MOHANLALL asked the Minister of Health Services and Welfare:

(1) What amount was budgeted for his Department for the 1989-90 financial year;

(2) (a) what amount remained unspent by his Department at the end of that financial year and (b) for what reasons had it not been spent? D154E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) R218 469 000.

(2) (a) Not yet established.

(b) Falls away.

Mr M MOHANLALL: Mr Chairman, arising out of the hon the Minister's reply, would he please give an indication as to when this information will be available, as well as an assurance that when the information is available, he will bring it to this House?

The MINISTER: Mr Chairman, in order to put this matter in perspective: Although the financial year ends on 31 March 1990, the books only close, on the instructions of the Auditor-General, on 30 June 1990, because various accounts have to come in, and the final report will be submitted by 31 July 1990. Thereafter I will let the hon member have it.

Shallcross/Chatsworth: link road

*4. Mr M Y BAIG asked the Minister of Housing:

(1) Whether he announced the allocation of approximately R2 million to provide a link road between Shallcross and Chatsworth; if so, (a) when and (b) what progress has been made in this regard;

(2) whether he will make a statement on the matter? D157E

The MINISTER OF HOUSING:

(1) Yes.

(a) June 1989.

(b) The preliminary design and layout plan for the link road and a report on the environmental impact which was prepared by a firm of consultants and other relevant documentation were submitted on 3 April 1990 to the City Engineer, Durban, to approve the proposed road route and to include the road reserve in the Town Planning Scheme. A response is now awaited.

(2) No.

Mr P I DEVAN: Mr Chairman, whilst I welcome the approval of this link road, there are four departments and more than six parties . . .

The CHAIRMAN OF THE HOUSE: Order! The hon member must proceed with the asking of a question arising from the reply.

Mr P I DEVAN: Mr Chairman, arising out of the reply, as several parties and departments are involved in the construction of the link road, will the hon the Minister consider the convening of a meeting of all departments concerned in order to expedite the matter and avoid delay in the construction of this road?

The MINISTER: Mr Chairman, a firm of consultants were appointed and it is their duty to organise the entire programme, its planning, etc. and when the municipality has approved that link road, the other steps will be set in motion. What the hon member for Cavendish is talking about will be taken care of by the different authorities responsible.

Cape residents petition for health bond scheme

Sowetan 11/5/90

SOWETAN Correspondent

ENTHUSIASM for a state "Health Bond" scheme to inject capital in to the country's ailing health services is mounting as thousands around the Peninsula sign petitions.

A Fish Hoek woman, Mrs Sandra Burman, telephoned *The Argus* to say she and a team of others had collected thousands of signatures in the Simon's Town constituency during the past three weeks.

Chronic

"We even have 90-year-olds collecting signatures at the home for the aged!"

Burman's concern for the chronic state of South Africa's health services, in particular the major teaching hospitals, prompted her to start a petition in Fish Hoek, Simon's Town and Kommetjie calling on the State President, Mr F W de Klerk, to authorise a Health Bonus Bond scheme in the same way as funds were raised for Defence in the late 1970s.

All have right to strike - doc

THE National Medical and Dental Association believes that all workers should have the right to strike to back up their demands against their employers.

Namda spokesman Dr Max Price made this point after strikes at several hospitals last week at which some doctors and nurses took part.

He issued a statement yesterday saying his organisation supported the strike by doctors and nurses but that such action should not have a detrimental effect on patients' health.

He said: "There are many forms of industrial action besides a full-blown strike. For example, tea- and lunchtime stoppages, work to rule, protest and pickets, and go-slows."

He explained that certain activities, such as emergency care at hospitals, could be excluded from the industrial action, so that only medical care which can be delayed without affecting patients' health (should be part of the industrial action).

All of these, if properly co-ordinated by a strong trade union which has ready access to members, can be done in a way which does not affect the health of patients, although they may certainly cause great inconvenience.

"Namda, therefore, supports the strengthening of the National Education Health and Allied Workers Union. We were impressed by the way Nehawu gradually escalated the level of the industrial action, and we blame the Transvaal Provincial Administration for not responding timeously - thus forcing Nehawu to take workers out on strike.

"If the TPA had taken Nehawu seriously at an earlier stage, the strike and consequent disruption of hospital services could have been avoided.

"The de facto recognition of Nehawu will, we believe, enable future industrial relations in the health sector to be conducted more constructively.

This will ultimately have a major positive impact on the health of all patients in the future.

P (85) Star 15/5/90

Cash crisis ahead for health group

CAPE TOWN — The Medical Research Council is faced with a negative growth rate on its budget which has put "serious constraints" on its programmes.

This was made clear in the council's report for 1989 tabled before Parliament yesterday.

MRC president Dr Philip van Heerden said the "current system of baseline financing, which stipulates that from now on the MRC must finance any increase in its research budget with self-generated income, has put serious constraints on all its programmes."

The percentage growth on the baseline was "way below the current inflation rate, and in real terms, the total operating budget therefore has a negative growth rate."

The council celebrated its 20th anniversary in 1989, and also undertook major management changes.

It had felt the need to review its mission and to launch intensive investigations into the appropriateness of each programme.

As for future strategy, Dr van Heerden said it had to examine if the manner in which research is practised, supported and managed is still suitable in a rapidly changing South Africa.

Cost effect

It would devise a future strategy during 1990 — "not only to solve problem areas, but also to prepare for a new period of growth".

The council had recently decided in principle to completely revise its system of work communities, because it was felt they might not be cost effective.

In an attempt to meed the needs of supplementing its research budget through self-generated income, the MRC intends to "market the expertise acquired over many years".

The interaction between man and his environment was chosen as the theme for the report.

Research highlights for the year have included the first steps towards a full-scale study on air pollution in the Vaal Triangle, and a pilot survey of pollution of the sea through effluent dumping.

Current research programmes into malaria, bilharzia, Aids, tuberculosis, urbanisation and health, heart attacks and heart disease, the importance of exercise, and nutrition in developing communities, are all well-advanced. — Sapa.

New national health po

Hosp

apar

scrap

CAPE Times 17/5/90 (85)

Political Staff

HOSPITAL apartheid is dead — and with it goes segregation in ambulances.

The Minister of National Health and Population Development, Dr Rina Venter, yesterday outlined a new national health policy which not only spells the end of racial discrimination but also places the emphasis on primary health care — and socio-economic upgrading.

She told Parliament health services were to be restructured to provide the best possible care for all and to eliminate facilities being under-used, which would clear the way for the transfer of patients from heavily overcrowded hospitals to others with empty wards.

Before her speech in Parliament she told a press conference that the critical overcrowding at Durban's King Edward VIII Hospital had "top priority".

She said hospital superintendents would make the final decision on how hospitals would be integrated, but a set of guidelines would be provided.

Health Minister Dr Rina Venter leaves Parliament last night after her announcement on open hospitals. Picture: ERIC MILLER

This would depend to a certain degree on the needs of patients and what sort of hospital was concerned.

Though Dr Venter would not confirm it, it appears that "own affairs" health structures will be all but eliminated and it is understood that the 44 hospitals now under white "own affairs" control will be opened in the same way as the other 246 hospitals run by the provinces.

Other innovations she announced yesterday were that "private" patients in state hospitals would be charged "professional fees" instead of the nominal amounts and that the private sector could become involved in state hospitals.

But, she said, "the idea is not to sell hospitals".

She explained that private doctors might be able to lease parts of existing hospitals.

Dr Venter also said that greater emphasis would be placed on primary health care, through mobile clinics and easy-to-erect clinics, in underdeveloped areas in an attempt to relieve the pressure on hospitals.

Socio-economic upliftment and a health education programme could prevent some people from having to be treated in hospitals.

Asked if hospital apartheid was dead, she replied: "The government has said apartheid is dead, so I would say yes."

She also confirmed that separate ambulances would be ruled out.

In her address, she said one of the aims of a health programme was to ensure the accessibility of health care to all people.

In squatter camps and rural areas it often was not available at all.

But, she said, working on a norm of three hospital beds per 1 000 people there was a surplus of 11 700 beds in white hospitals and a shortage of 7 000 beds in black hospitals.

"To correct this the government has decided that the available capacity of beds in all hospitals must be accessible to all persons and that a model for orderly management be designed," she said.

'Expensive' transplant operatio

HEAVILY subsidised organ transplants, such as heart and liver transplants, for foreign patients at South African hospitals are on the way out.

The Minister of National Health, Dr Rina Venter, said in her policy speech yesterday that it had already been approved that academic hospitals, which received 43% of the total health budget, would be able to increase their own income.

"This will mean that in future private patients will have to pay for the professional services which they receive at academic hospitals."

However, she also said certain hospital procedures, such as organ transplants, were "simply too expensive and cannot be financed by the private sector".

"To date the state bears the greatest responsibility for that kind of health service which is dependent upon expensive highly technological procedures.

"The fact that the private sector cannot bear responsibility for highly technological procedures, causes a very serious problem in all countries to provide this kind of health service."

It is reliably understood the government is considering ending expensive organ transplants for foreigners, unless they pay for the costs, and only providing subsidies for transplants for South African patients.

Meanwhile medical personnel have welcomed yesterdays's announcement that hospital apartheid is to be scrapped.

The superintendent of Tygerberg Hospital, Dr J G L Strauss said: "This move will certainly make more beds available although the limiting factor is still the shortage of nursing personnel. He said he forsaw no problems in the implementation of the changes.

The superintendent of Groote Schuur Hospital, Dr Jocelyn Kane-Berman said

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Cape Times
17/5/90

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The superintendent of Groote Schuur Hospital, Dr Jocelyn Kane-Berman said the announcement was welcome and would be in the general interest of hospital services throughout the country.

A medical officer at a provincial hospital told the Cape Times that years of apartheid had left most hospitals impractically designed, and it would be difficult to implement changes.

However it was "the only sensible thing to do in the light of the economy of the health services and the future of South Africa".

He felt, however, that the changes may lead to dissatisfaction of some patients but with judicious planning "these sort of problems can be overcome," he said adding that the integration of some of the other hospitals had led to white patients "scurrying to the private hospitals".

A senior medical officer said the announcement was "long overdue" but would nevertheless greatly improve the drastic situation in the hospital services.

Dr John Steer, a spokesman for the Medical Association of South Africa, said the association had pursued this end for many years.

"It is a long overdue move but absolutely fantastic and can only benefit medicine in the country," he said.

The National Medical and Dental Association said it cautiously welcomed the steps but was concerned that the amount of emphasis placed on the privatisation of health care services had led to very few whites using the public health care services anyway.

"We are also afraid that only the white beds will be opened to blacks which is not the same as equal health care for all," said a spokesman yesterday.

"Often the overflow from the black side goes to the white wards so that the whites are still in a privileged position — the steps must lead to complete equality," he said. — Staff Reporter and Sapa

Hospital race laws will be abolished 'without delay'

20/5/90 S! Times

By NORMAN WEST: Political Reporter

ALL South Africans, regardless of colour, will from now on be obliged to take their medicine in mixed wards and no nonsense.

And stubborn hospital superintendents who persist in using colour as an excuse to exclude patients will be severely dealt with, Health Minister Dr Rina Venter has warned.

She also announced yesterday that legislation was being prepared to implement the Government's directives to scrap apartheid in hospitals. The new laws could be introduced in Parliament during the current session.

She said the open-hospitals policy was being implemented with the agreement of the "Own Affairs" Health Ministers, Dr Sam De Beer (Assembly), Mr Chris April (Representatives) and Mr Baldeo Dookie (Delegates).

There was a surplus of 11 700 beds in "white" hospitals and a shortage of 7 000 beds for "blacks", so no new hospitals would be built in the short-term until the under-utilisation of beds had been corrected.

She stressed the policy would be implemented immediately and was binding on all provinces and all superintendents.

She said a management model for open hospitals was being developed. Race would in future be irrelevant.

She said superintendents would be subject to central policy and be responsible for the standard of services to all patients.

"If it came to my attention that any superintendent had neglected to implement this new dynamic policy, or that he had caused any patient to be disadvantaged in any way, he will be dealt with swiftly and effectively," said Dr Venter.

Dr Venter emerged as a no-nonsense reformist during the debate on her ministry's budget this week.

She said the CP had raised "no real objections" to the policy's basic principles "which illustrates that only these adjustments can ensure workable and honest management of health services in the future".

When Labour Party MPs persisted in expressing scepticism about the new policy, Dr Venter told them bluntly that the time had come for them "to write new speeches".

"Certain members seem to find themselves in trouble because the things they want to shout about have dried up," she said.

RINA VENTER
No-nonsense reformer

Masa to host health summit

GERALD REILLY

PRETORIA — The current crisis in health care services must not be allowed to deteriorate into a paralysis of health care, Medical Association of SA (Masa) secretary general H A Hanekom said yesterday.

At a media conference he said the training of doctors was the hub around which the standard of medical care revolved.

Announcing a "high level" conference on academic medicine from May 28 to May 30, Hanekom said Masa regarded the threat to academic medicine in a very serious light.

Experts in the field of medical education, including medical school deans, medical administrators and teaching hospital superintendents, would attend.

The "summit" would be opened by National Health and Population Development Minister Dr Rina Venter.

Hanekom said attention would be focussed on the causes of the current crisis and not only on symptoms such as outmoded equipment, salaries of doctors and nurses, and hospital workers' strikes.

He warned that SA could not afford to treat adademic medicine and the training of doctors in an ad hoc way.

NO DICE

Nationalist MP Hennie Bekker's strong plea for a State lottery, to help finance health services, has been unconditionally rejected by Health Minister Rina Venter.

Speaking in parliament last week, Bekker, MP for Jeppe, said the time had come to give serious attention to a lottery. He pointed out that New York, Ireland and many African states used lotteries to boost funds for social services. While acknowledging the sensitivity of the issue, he argued that if it were legal to gamble on horse races and at casinos in homelands it was surely possible to deal effectively with the question of a lottery.

Venter wasn't interested. She gave parliament a categorical assurance that no changes to the Gambling Act were being considered to allow for a lottery. "This has been thoroughly investigated and is not an option in our current society."

Star 29/5/90 (85)

NEWS

'Primary health care must receive priority'

Own Correspondent

South Africa, with its limited funds and manpower, cannot afford to train doctors who do not meet the basic health needs of the people.

This was the message from Minister of National Health and Population Development, Rina Venter, to a leaders' summit on the future of academic medicine in South Africa held at Magaliesburg yesterday.

Maximum and effective use would have to be made of available funds and manpower, she said, and the summit should consider whether the curriculum content in medical schools reflected the national health priorities, with their emphasis on primary health care.

Hospital care was not the biggest need in South Africa and focus of attention would have to move to primary health care, said Dr Venter.

It was a waste of money to handle simple complaints in a hospital, but this often happened because community services were inadequate. More attention should also be given to preventative medicine. Last year more than 300 children died unnecessarily of measles, a preventable illness.

The restructuring of health services would have to start with the socio-economic upgrading of communities,providing water, sanitation and better education, and reducing the high road accident and crime rates.

As long as South Africa had one of the highest accident figures in the world there would be a shortage of beds for trauma in intensive care, and as long as it had a high crime rate casualty sections would be overflowing, said Dr Venter.

Health care costs for the very young and the very old were higher than that for the rest of the population. The fact that 43 percent of the black population was under 14 and 9 percent of the white population "old", coupled with a high rate of urbanisation, meant high costs for South Africa.

But the standard of health care provided by a government depended on the wealth of the country, and South Africa was already spending 5,4 percent of its Gross National Product on health care and could not afford dramatic change, Dr Venter said.

The 13 academic hospitals used up 43 percent of the total health budget, and there had been repeated pleas that their share be increased.

Comparisons

She said although comparisons between academic hospitals were difficult (one had a budget of R301,7 million while another with more beds had to get by on R147 000), funds had to be allocated by criteria based on research of actual financial needs, rather than on traditions, status and achievements.

Academic hospitals were getting more management independence, and the opportunity to increase their income by charging private patients for professional services.

A moratorium had been placed on the building of new academic hospitals, and existing facilities were to be used more effectively. At a norm of three beds per 1 000 population there was a surplus of 11 700 beds in white hospitals and shortage of 7 000 in black, she said.

Venter prescribes health care remedy

85

Sowetan 29/5/90

THE South African Government would for many years to come not be able to afford dramatic changes in its health care budget, Health Minister Dr Rina Venter, said in Magaliesberg yesterday.

Venter was delivering the opening address at a conference on the future of academic medicine organised by the Medical Association of South Africa.

She said the challenge for all responsible actors on the health scene was co-operation in utilising available funds to their maximum and most efficient manner.

South Africa was spending 5,4 percent of its Gross National Product on health care. Only 21 percent of the South African population could afford its own medical costs, which meant almost 80 percent of the population relied on the State for health care, Venter pointed out.

"The reconstruction of health care services must accordingly take place within the financial abilities of the State."

With reference to poor existing socio-economic conditions, Venter said the answer to health care for all lay not only with the hospitals, but also "outside in the community".

She said:"According to a United Nations report, a one percent rise in female literacy is three times more effective in reducing child mortality than a one percent rise in the number of doctors. This clearly demonstrates the linkage of the population development programme and health care."

She said there was "near universal consensus" that there was substantial inequality and inefficiency in terms of allocation of health care, leading to an undercurrent of consumer discontent about the way in which health care services were provided.

Venter said all governments accepted that good health care affected the health of the whole community. Good health care was, therefore, the goal of this Government, she said.

She outlined guiding principles which would serve to address health care:

* The rights of all people to have access to health care, which must incorporate a high priority role to primary health care.

* Efficient health care programmes which take into account health care requirements of the whole population.

* Affordability. About 10 percent of the present Budget was allocated to health services, but R21m was presently needed to put into operation 26 health centres not in use, while another R200m was needed to upgrade existing equipment in hospitals.

Health services in peril — UCT head

Star 29/5/98 By Carina le Grange 624 85

Patient care in South Africa's academic hospitals was under threat and therefore the whole health service was at peril, according to the principal of the University of Cape Town, Professor Stuart Saunders.

He was speaking yesterday during the opening session in Magaliesberg of the Summit on the Future of Academic Medicine, organised by the Medical Association of South Africa.

Professor Saunders said of 2 133 specialist posts at the seven academic hospitals in South Africa, 302 were vacant, indicating a serious crisis in health care in general and in academic medicine in particular.

He said it was in medicine that South Africa was truly part of the First World in some achievements.

"The teaching hospitals are a place where research is done, research which keeps the members of those hospitals up to date with the most recent advances, to the direct advantage of the patients under their care," he said.

Among his recommendations, he mentioned the necessity of desegregating medical care and said he "applauded the recent statement of the Minister of Health, Dr Rina Venter, in this regard". Divisions between general and own affairs departments must go, since fragmentation was costly and inefficient.

A comprehensive health service with rural and urban clinics staffed by health care workers was needed, backed up by larger health centres from where patients could be referred to regional or district hospitals, and if necessary, ultimately to an academic hospital. In this way academic hospitals would be protected from being overwhelmed.

He said: "We must allocate as much as we can to education and to health. The recent (budget) cutback in the Cape, and I would like to know what the position is elsewhere, is nothing short of disastrous. It is short-sighted and close to being scandalous ... It is political dynamite."

Star 24/5/90 (85)

Garbage: the hated bogy of shantytown

By Winnie Graham

Urbanisation

The people who live in the shacks of Pola Park have come to terms with shantytown life.

They have learnt to make do with hopelessly inadequate toilet facilities, a shortage of water, only the occasional bath, the cold in winter, the heat in summer, smog in the mornings and a lack of privacy.

Most, of course, dream of the day they will escape the overcrowded confines of the squatter camp to live in a house of their own choice but, for the moment, they survive in a world they can't do much to change.

While they cope as best they can, the people have one pet hate: the garbage accumulating round them.

Most squatters come from the rural areas, where garbage was not considered a problem. There, people grew most of their own food, and leftover scraps were consumed by pigs and chickens. The disposal of plastic bags, polystyrene, empty tins, cardboard boxes or wrappings was not an issue.

Miriam Molefe says the women cannot stand the garbage that collects on the verge of the camp.

No one removes it — or buries it. When the rains come, the pile is converted into a slimy green cesspool. In hot weather the smell is intolerable.

In Pola Park, the garbage is left to accumulate for months, attracting flies and rats. And bored, undernourished youngsters love rummaging through it.

"That's the problem," Mrs Molefe said. "When the children play in that filth they get sick."

Nursing sisters working in a small clinic supplied by the Alberton Industries Association confirm that scabies and diarrhoea are the most frequently treated ailments at Pola Park.

The playing fields of Pola Park . . . children of the Reef squatter camp photographed against a background of garbage.

Few can afford own treatment — Venter

Carl Trait 29/5/90

Own Correspondent

PRETORIA. — Only 21% of South Africa's population could pay for its own medical services and the state was often responsible for the provision of high-tech services, National Health and Population Development Minister Dr Rina Venter said yesterday.

Speaking at a conference on the future of academic hospitals, she said the goverment would for the foreseeable future remain the biggest role player in the field of health.

It was clear to all, particularly in the squatter settlements and in the deep platteland, that health services were often not available, she said.

She denounced the argument that fragmentation of health services was the greatest cause of the country's health care problems as an over-simplication of a complex problem.

One solution was to increase the incomes of academic hospitals, which meant private patients would have to pay for professional services at academic hospitals.

While many hospitals were overfull, other hospitals were totally under-utilised, she said. The surplus of beds in white hospitals was estimated at 11 700 against a shortage of 7 000 in black hospitals.

As long as families had to live in poor socio-economic conditions where there was no clean water or sanitation, there would be a shortage of beds for babies with gastro-enteritis. SA had one of the highest road-accident figures and therefore there was a shortage of beds in intensive-care units.

And as long a the violence associated with poor living conditions persisted, casualty stations would be overburdened with the victims.

Answers therefore did not lie in the hospitals but in the communities.

munity for six weeks before said Mr Pyne-James.

Medical summit plans 'ideal' health care system

Star 30/5/90 85

By Carina le Grange

An "ideal" vision comprising a comprehensive health care system for South Africa has been drawn up by delegates to the Magaliesburg Summit on Academic Medicine.

The three-day summit, organised by the Medical Association of South Africa, ends today.

Just and fair

Delegates resolved that the ideal is an "affordable, non-racial, comprehensive, effective, unitary health system to which all have the right of equitable access".

This system would be characterised by the allocation of health resources to each level of the health system, determined by "just and fair" criteria which must be accountable to the community and subject to audit and peer review.

It must have management systems promoting sound decision-making at all levels, with decentralised responsibility and authority, and with the private and public health sectors co-operating in providing health services subject to appropriate regulation.

Providers of health services in this system must be appropriately trained, supported and rewarded and "academic centres of excellence are an essential component of the health system".

The new health system is to be involved in, and encourage, other socio-economic measures to improve the health status of all. Delegates said health education and health services encourage and enhance individual and community participation.

Doctors

In a statement, Masa reiterated that the standard of health care is determined by the training of doctors.

"Academic medicine is therefore of critical importance for the provision of health care.

"The training of the providers of health care cannot take place in isolation, but forms an integral part of South Africa's health system," the statement said.

Health care for all Masa's vision

JOHANNESBURG. — The Medical Association of SA (Masa) summit on academic medicine has formulated a vision for health care which involves a unitary health system to which all have the right of access.

A statement issued yesterday from the summit in Broederstoom, Transvaal, said the training of providers of health services could not take place in isolation but formed an integral part of SA's health system.

The three-day conference, which ends today, was addressed earlier this week by Health Minister Dr Rina Venter, Gencor executive finance director Mr Tom de Beer and University of Cape Town principal Dr S J Saunders.

It was attended by about 100 of the country's top medical decision-makers, including academics and provincial administration authorities.

A Masa spokesman said there had been no significant move away from previously stated policies of Masa at the summit. However, resolutions adopted by the summit — which addressed the question of the future of academic medicine — had been more strongly stated than before.

The summit resolved that "the ideal system is an affordable, non-racial, comprehensive, effective, unitary health system to which all have the right of equitable access".

There are 14 different health departments in South Africa.

The Masa summit suggested that:

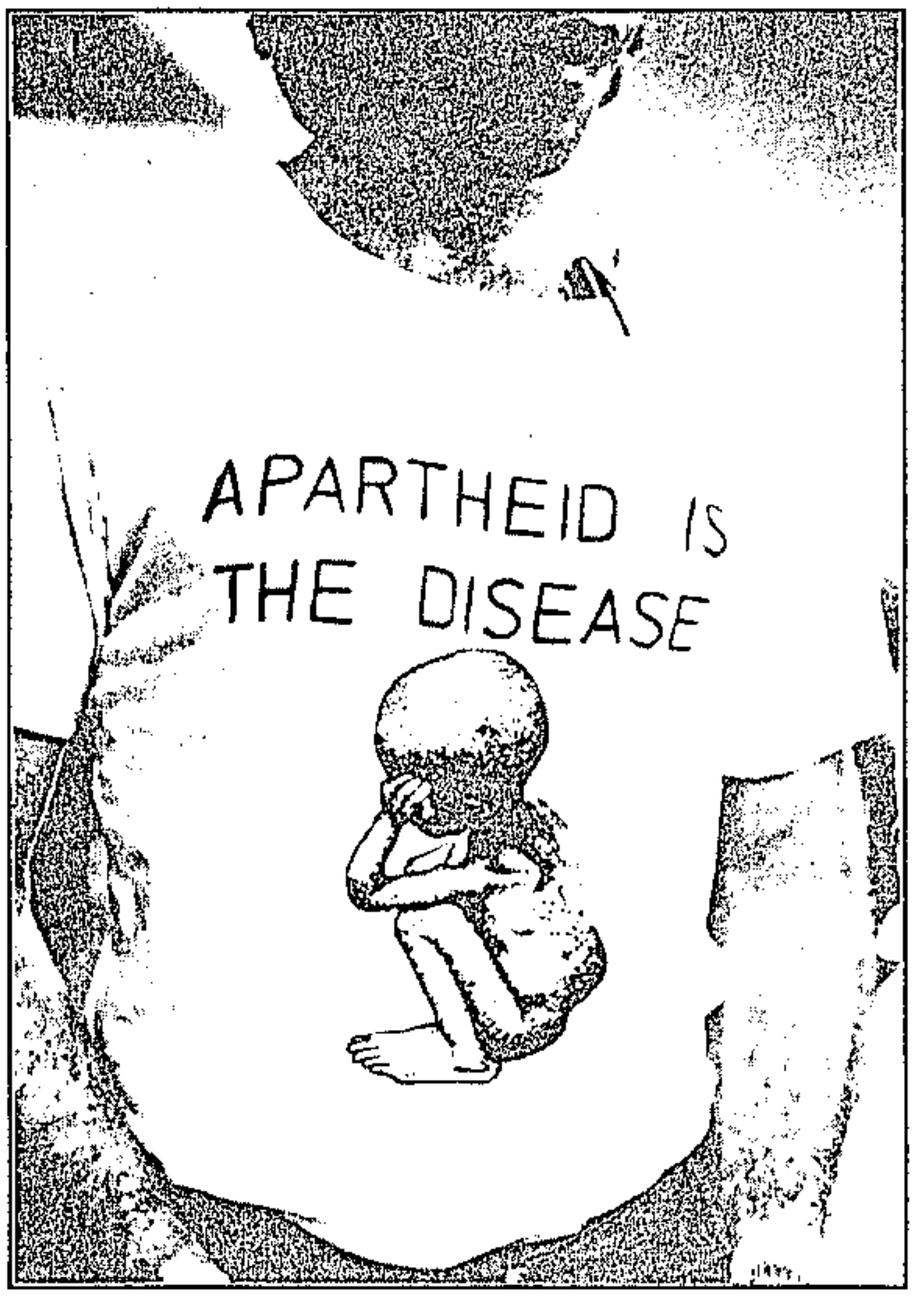
- **The allocation of health resources to each level of the health system be determined by just and fair criteria.**
- **The system be accountable to the community and subject to audit and peer review.**
- **Management systems promote sound decision-making at all levels, with decentralised responsibility and authority.**
- **The private and public health sectors co-operate in providing health services and are subject to appropriate regulation.**
- **Providers of health services are appropriately trained, supported and rewarded.**
- **The health system is involved in, and encourages other socio-economic measures to improve the health status of all.**
- **Health education and health services encourage and enhance individual and community participation.**
- **Academic centres of excellence are an essential component of the health system. — Sapa**

South 30/5 - 6/6/90

Health in 'new' SA: debate starts

(85)

As South Africa moves towards a new society, debate rages on various aspects of life. A special writer looks at the health sector, and means of creating a fair and equitable health service:



THE Constitutional Guidelines of the African National Congress (ANC) are being seriously debated in many organisations.

The debate has tended to focus on the obvious, more immediate constitutional aspects of a post-apartheid South Africa such as the vote and the economy.

An important area now being drawn to the public's attention is the inclusion by the South African Health Workers' Congress (Sahwco) of a health clause in a future constitution.

In a booklet called "Health and the Constitution Guidelines for a democratic South Africa", Sahwco argues for the formulation of such a clause.

More than ever before, the oppressed and exploited masses of South Africa and their organisations are called upon to prepare to govern.

This needs more than slogans or broad visions which express the desire for freedom and justice.

The most systematic vision of a non-racial, democratic, unitary South Africa was set out in the Freedom Charter, adopted at Kliptown 35 years ago.

"The stage is now approaching where the Freedom Charter must be converted from a vision of the future to a constitutional reality," noted the ANC in its presentation of the Constitutional Guidelines For A Democratic South Africa in 1988.

The new constitution must at least contain the principle of equal health care.

The Constitutional Guidelines themselves are silent on the question of health and health care.

This makes the debate on the formulation of such a clause even more urgent.

At a Sahwco conference last year, at which the ANC participated through a telephone link-up, ANC national executive committee (NEC) member Pallo Jordan was questioned about this omission.

Jordan, who was also part of the ANC committee which drafted the Guidelines, threw the ball back into Sahwco's court. He replied that the responsibility for for developing a health clause in the Guidelines was not that of the ANC alone.

All democratic forces concerned with health care and social services had to take on this task.

Sahwco has responded to the challenge by presenting their arguments on such a clause for public debate.

The demands on health in the Freedom Charter and those that have been brought forward by more recent health campaigns should guide thinking in the formulation of health clause for a new South African constitution, says Sahwco.

The health clause should include the principles upon which health care in a post-apartheid South Africa would be based. A particular health policy and strategy would flow from these principles.

Using the Freedom Charter and recent health campaigns as guidelines, Sahwco lists the following principles:

- Health care is a basic human right;
- Provision of health care is the state's responsibility;
- Health care must be comprehensive;
- The health of workers must be protected;
- There must be a commitment to preventive and primary health care;
- There must be mass participation in and consultation on health care and health issues;
- Privatisation of health services should end;
- Health services should be centrally planned and democratically controlled under a National Health Service;
- Health care must be free; and
- There must be equal and accessible health care for all.

Similar principles are likely to emerge from continuing campaigns on health issues, such as the Health Charter Campaign, adopted at the Conference For A Democratic Future (CDF) in 1989.

Given the present gross imbalances in South Africa's health services, the new constitution must at least contain the principle of equal health care, argues Sahwco.

This can be possible only if there is a single, non-racial department.

Although a constitution is unable to address specific questions on removing present obstacles to equal health care, it must commit the new government to this principle.

It might also be useful, suggests Sahwco, for the new constitution to provide for the role of mass grassroots health structures in a future health system.

Research

Sahwco carried out research in 50 countries on how these dealt with health in their constitutions. There were four basic ways:

- Some countries made no reference to health or health care at all in their constitution. Examples here include South Africa, Australia and Finland.
- In some constitutions, health care was set out as a right among other health principles. There was also a guiding principle for social and economic policy. Sweden, Spain and Guinea-Bissau fall into this category.
- Some constitutions went beyond a statement of health principles and included aspects of health policy such as financing and the structure of health care. Nicaragua, Cuba and Portugal are examples of this.
- Health care was also used as a means of social control in El Salvador, it was found.

Although the impact of reference in a constitution to health and care on the actual health system remains to be examined, Sahwco emphasises it is beyond doubt that a good constitutional clause on health can be the basis of a sound health policy.

Although health is not seen as a priority area of organisation among most mass organisations, the issue of health and health care has been receiving more attention over the past few years.

In the wake of the 1986 Kinross mining disaster which killed 177 black mineworkers, the National Union of Mineworkers (NUM) focussed attention on health and safety in the workplace.

Under the slogan, "Organise or Die", the union began a campaign to raise awareness of health hazards on the mines and how these could be dealt with.

They drew up a safety code, demanded the right to safety stewards and independent union investigation when accidents occurred.

Outside the workplace, longstanding grievances about the availability and quality of health care were also being voiced more consistently and determinedly.

Response

In 1988, more than 250 000 people in Natal signed a petition calling for free health care. This was in response to a decision by the Natal Provincial Administration to increase hospital fees.

For the first time pensioners, disabled people and the unemployed were expected to pay for health care.

The campaign against the increases also raised demands for:

- A National Health Service;
- Decentralisation of health services; and
- Equal health care for all

The Defiance Campaign of 1989 began with the campaign to desegregate hospitals. Thousands of black patients presented themselves for treatment at white hospitals with a clear demand: "Open all hospitals to all people!"

On March 24 1990, Johannesburg health workers marched to the JG Strijdom Hospital, "renamed" it the Dr Yusuf Dadoo Memorial Hospital, and handed over a petition to the hospital superintendent.

The petition called for, among other things:

- A unitary National Health Service, centrally planned and democratically controlled, adequate and accessible to all;
- The immediate suspension of own-and general affairs legislation applying to health services, and the immediate desegregation of all health facilities;
- A rejection of privatisation as a way to end the health care crisis, as this would place it further beyond the reach of those who most needed it;
- A moratorium on all hospital tariffs until an in-depth investigation into these had been concluded;
- Proposed amendments to health legislation should be be considered in consultation with democratic and progressive non-state structures;

A march by Durban health workers in April 1990 had similar demands, some of which have been nurtured by oppressed South Africans for more than 35 years.

Vision

Enshrined in the Freedom Charter is the vision that the health system in a non-racial, democratic, unitary South Africa will have:

- "... Sick leave for all workers, and maternity leave on full pay for all working mothers." (Clause 7: There shall be work and security!)
- "A preventive health system shall be run by the state. Free medical care and hospitalisation shall be provided for all with special care for all mothers and young children. The aged, the orphans, the disabled and the sick shall be cared for by the state. Rest, leisure and recreation shall be the right of all."(Clause 9: There shall be houses, security and comfort!) — *The New African*

Sachs urges 'culture of debate'

South 30/5 - 6/6/90

(11A) (30-4A)

WHILE racism in a future South Africa should be countered in people's daily lives, when it became "fighting talk" action would have to be taken, believes ANC constitutional expert Albie Sachs.

Speaking in Port Elizabeth, Sachs gave some insight into the ANC's views on the present and a constitution for South Africa.

Examples

He said features of systems in Scandinavian countries could offer examples to constitution-builders in South Africa.

Countries like Sweden were democratic, boasted a strong trade union movement and had an advanced state welfare system which guaranteed education, housing and health care.

They had also been poor countries in the not too distant past, "with millions of people leaving Sweden, for example, because of hunger", he said.

Although Scandinavian countries, and some in southern Africa, could offer helpful examples, Sachs believed the only model for South Africa was South Africa itself.

While group rights were not on the ANC's agenda — the concept perpetuated apartheid and, if insisted upon, would lead the country along a "very stormy road" — language and cultural rights could be protected. Sachs said a possibility could be the establishment of elected councils to deal with language rights.

The Law Commission's Bill of Rights proposals corresponded with the ANC's position on just two points — they rejected the concept of group rights and acknowledged all other rights were meaningless without the right to vote.

Sachs stressed the importance of taking "the constituent assembly route" to a new South Africa. In Namibia the war ended when elections were held for the country's constituent assembly, which had a "calming effect" on society.

He said there should be debates and discussions at grassroots level on the development of people's demands for constitutional goals.

The whole society should contibute to the drawing up of a new constitution. Workers' and women's charters would have to be attached the constitution.

A charter of "religious rights, freedoms and responsibilities" should be drawn up, and land rights, encompassing rights of tenants, landowners and workers, should be investigated.

Encourage

Sachs said a culture of debate around a future constitution should be encouraged, and groups like the PAC - which should be allowed what he called "the right to be wrong" - had to be drawn into that debate.

He encouraged lawyers of the National Association of Democratic Lawyers to move from their present "defensive role" to one in which they use their skills to work for a new constitution. — *PEN*

Community health workers to play key role in medicine

(85)

Star 15/6/90.

By Shehnaaz Bulbulia

As many as 60 percent of patients treated at hospitals could be dealt with by community health workers, deputy director-general of the Department of National Health and Population Development, Dr Hans Steyn, said in Pretoria yesterday.

Speaking at a press conference on the role of community health workers, Dr Steyn said they could play a key role in preventative medicine.

"They form an integral part of the process to provide primary health care. Community health workers could also see to it that patients who are discharged from hospital comply with their treatment," said Dr Steyn.

Keeping in line with the current national trends, Dr Steyn said the new health policy stipulates that health care be brought as close as possible to the user of health services.

"There are only 300 community health workers countrywide. Because of this the department is treating primary health care as a high priority," he said.

Dr Steyn said that the department believes that the principles of health care are not only to be as equitable, effective and accessible as possible, but to be equally socially acceptable and affordable. The community health worker, he said, would serve as a bridge between the health system and the community.

Dr Steyn said in recognition of the importance of the community health workers' role in the health system, a day-long summit was organised last month in which different sectors concerned with health spelt out broad guidelines for such workers.

It was decided that each community would appoint its own community health workers with the aim of addressing fundamental health problems, he said.

Further, community health workers should not be on the state pay-roll because they are accountable to the community they serve. However, Dr Steyn added that organisations hiring such workers would be subsidised by the Government.

The 'shacklord' school principal

Parents ring alarm bells over shack 'health hazard'

By ELIAS MALULEKE

A SOWETO school principal has been accused of allowing the erection of shacks on the school premises and of collecting rent from shackdwellers.

Parents are worried the principal of Thembalihle Lower Primary School in Orlando East, Sana Dikgale, is turning the school into a "health hazard".

By last month five shacks had sprung up on the school grounds, but this dropped to three recently after two families moved out.

Parents say their children can no longer use the toilets because the squatters and their friends are not keeping them clean.

In one shack, more than two families live together in a tiny room.

The parents also fear the shackdwellers may molest their children. They told *City Press* that three young lodgers who share a room loiter around the school during the day.

The day after *City Press* spoke to the lodgers, Dikgale said there was no squatting on the premises. She also refuted allegations that she was collecting rent from them.

Petrus Hlongwane and Karimindo Dhlamini, two unemployed men who share a tiny shack with Petrus' brother, said they each paid the principal R30 a month.

They said that in February they moved in with Michael Hlongwane, who built the shack. Dhlamini said they had nowhere else to stay.

He said two other shackdwellers who could not afford to pay their rent were forced to move.

Simon Madondo, 45, who lives with his common-law wife – an inyanga who practices in their tiny shack – said he was not paying rent because he was asked by the principal to help guard the school.

"When I came here early this year I found other shacks in the yard."

Dikgale at first said the presence of the shacks at the school "has nothing to do with newspapers because my school is private property. We can do what we want here."

However, she added that she allowed the squatters to put up shacks in the premises from late last year because there was only one watchman and the school had been burgled several times.

"I discussed the matter with the Management Council and they gave their blessing – and I can assure you that these people did not pay rent."

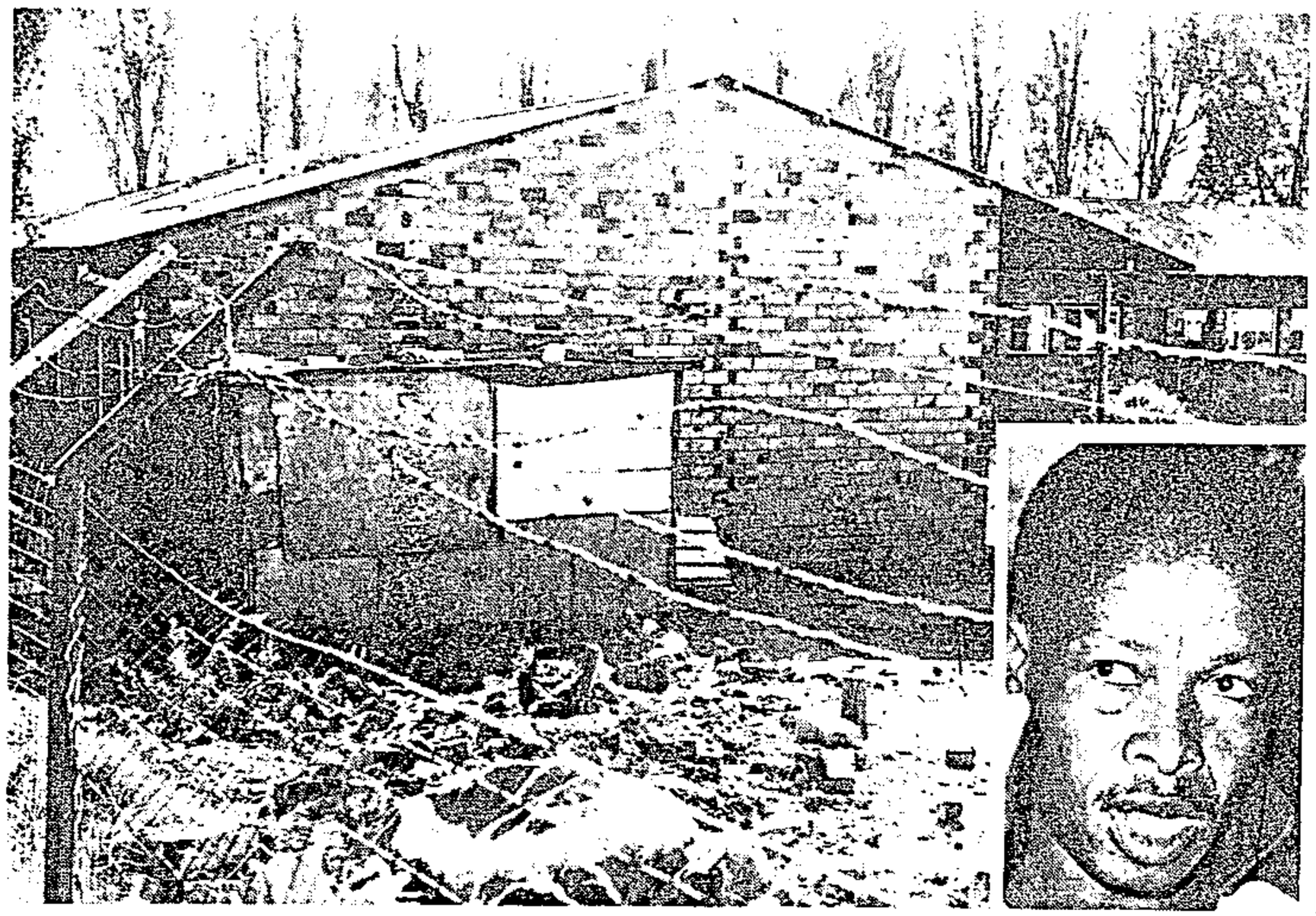
Dikgale said all the shackdwellers left "two months back".

She laughed when told that *City Press* had spoken to the squatters the previous day.

Management Council member BE Qaba said the council was approached by the principal last year and they opposed the idea of erecting shacks on the premises.

"We strongly asked her to evict all the squatters but nothing has been done. We intend to take stronger actions."

The DET said it was not aware of the shacks at the school and would launch an investigation.



One of the shacks that have sprung up at a Soweto school. Shackdweller Simon Madondo (inset), says he pays R30 rent a month for a shack he shares with three others. ■ Pic: ANDRIES MCINEKA

Masa president calls for unified health system

PRETORIA — An effective health care delivery system in SA depended on a unified health system, newly elected Medical Association of SA (Masa) president Andre Vercueil said last night.

In his opening address at Masa's AGM he stressed fragmented health departments were wasteful and inefficient.

A streamlining of functions would lead to greater cost effectiveness.

Vercueil said the big financial institutions such as insurance companies had indicated recently they wanted to compete in this field.

Masa had pleaded for years for the abolition of discrimination in health care and the opening up of hospitals.

It would continue to plead for the

GERALD REILLY

total abolition of fragmented health services and a unified health system, he added.

Speaking at the same function, National Productivity Institute Executive Director Jan Visser stressed the need for better management in the health industry.

Some years back the NPI had carried out an investigation in 12 Transvaal provincial hospitals.

The findings were used as a basis for a strategic planning exercise involving the health authorities and a clear action plan was developed.

However, nothing came of it.

This left the unavoidable impression that the authorities were not prepared to swallow their own medicine, "and today we pluck the bitter fruit of these actions," Visser added.

Meanwhile, Masa federal council chairman Bernard Mandell yesterday announced Masa's recently formed science and education committee was to investigate generic substitution of medicines and their therapeutic efficiency.

Mandell said both doctors and patients needed guidance on the issue.

He said high technology in medical care would also be investigated. This would look at the importation, distribution and use of sophisicated equipment.

The registrar's association was also investigating the working conditions of junior doctors and the work pressure exerted on them.

Total number (metric tons) of products irradiated commercially in the RSA for the period 1 July 1989 to 31 December 1989

Product	Mass (metric tons) 1/7/89–30/9/89	1/10/89–31/12/89	Total
Torulite yeast	209,725	196,200	405,925
Meat	—	1,090	1,090
Mushrooms	—	0,053	0,053
Chicken	—	0,278	0,278
Strawberries	—	0,016	0,016
Dehydrated vegetables	3,630	5,174	8,804
FRN Squizy	—	0,640	0,640
Dried figs	4,660	18,065	22,725
Queen jelly	1,390	—	1,390
TOTAL	1 522,288	1 550,838	3 073,126

Minister of National Health and Population Development: lawsuits

452. Mr A E DE WET asked the Minister of National Health and Population Development:

(1) Whether any lawsuits were brought against (a) her/his predecessor in her/his capacity as Minister of National Health and Population Development and/or (b) any specified chief executive director of provincial hospital services in 1989; if so, what (i) were the circumstances of each lawsuit and (ii) was the outcome in each case;

(2) whether (a) her/his predecessor and/or (b) any specified chief executive director of provincial hospital services paid out any money in 1989 (i) as a result of successful lawsuits brought against them and (ii) in out-of-court settlements; if so, what amount in respect of each case?

B1045E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) (i) and (ii) Yes,

— application for military pension or alternatively a gratuity: Out-of-court settlement — no costs;

— injury on duty. Application for pension, indemnification and sick leave with full pay: Case pending;

— application for payment of medical expenses by medical scheme: Minister as second respondent won't oppose the application and will abide by the decision of the court;

— dispute between employer and employee over date of retirement: Minister as second respondent won't oppose the application and will abide by the decision of the court;

— dispute between employer and employee over a debt which was recovered from such employee's pension: Minister as second respondent won't oppose the application and will abide by the decision of the court;

— employee on bicycle colliding with plaintiff's car: Case pending.

(b) (i) and (ii) Yes,

Administrator: Cape Provincial Administration

None of the cases mentioned below have been finalised or withdrawn. Negotiations are still in progress in all of the cases.

— Allergic reaction to iodine after angiographic examination;

— fracture due to a motor vehicle accident. Experiences problems after removal of plaster of paris. Private orthopaedic surgeon alleged negligence;

— patient loses his sight after several tests performed on him in hospital;

— alleged undiagnosed head injury;

— intra-muscular injection caused gangrene;

— ulna nerve injured from elbow to fingers due to alleged negligent administration of anaesthetic;

— facial paralysis due to Meniere's disease;

— chemical burns to both eyes and forehead due to Cidex left in the anaesthetic mask;

— patient allegedly treated incorrectly after snakebite;

— patient goes into a coma after administration of anaesthesia resulting in loss of sight;

— baby suffers brain damage during birth due to alleged negligent conduct during the labour process;

— charges of assault laid against the medical officer by a patient referred for a blood alcohol test;

— treatment of injured finger leading to amputation of the finger;

— baby suffers injury during birth;

— operation on left instead of right ear;

— needle breaks off in breast during operation;

— periphery neuropathy due to alleged "Amiodarone" toxicity;

— patient dies after erroneous dosage of medication;

— allegation that irradiation was done negligently in an incorrect position. Patient experiences discomfort due to the alleged negligence.

— brain damage due to cardiac arrest during a tonsillectomy;

— patient suffers injuries to his ankle. Alleged irregular treatment as outpatient;

— both legs were later amputated after medication was administered for pain in the legs;

— alleged negligence during labour procedure;

— patient complains of pain. No problem can be traced during examination. Patient discharged and dies that same evening;

— septicaemia of operation wound;

— patient starts to haemorrhage during a confinement whereupon a catheter is applied which broke off in the vein;

— finger amputated after it turned septic due to a fish bone which was not removed;

— alleged incorrect diagnoses resulting in the amputation of both legs of a toddler.

Administrator: Orange Free State Provincial Administration

— Needle left in kidney during an operation: Case pending;

— loss of the use of both legs as a result of poor post-operative care after a cardiac by-pass operation: Case pending.

Administrator: Transvaal Provincial Administration

— Negligence during birth process: Case pending;

— negligence during sterilisation operation: Case pending;

— negligence during examination after motor accident resulting in permanent disability: Case pending;

— persistent pain in hip due to inefficient treatment after motorcar accident: Case pending;

— unsuccessful sterilisation resulting in an undesired pregnancy: Case pending;

— pain, suffering and discomfort caused by negligent treatment after motorcycle accident: Case pending;

— Patient died under general anaesthetic resulting from an insufficient oxygen supply to the brain: Case pending;

— indecent assault of a person by porter: Out-of-court settlement;

— unlawful dismissal of an employee: Out-of-court settlement.

Administrator: Natal Provincial Administration

None of the cases mentioned below have been finalised or withdrawn. Negotiations are still in progress in all of the cases.

— Injured right toe and leg on hospital premises;

— alleged negligence in the repair of a subtrochanteric fracture;

— corrugated drain left during operation;

— patient underwent an unrequested tubal ligation during a gynaecological procedure;

— allegation that negligent treatment resulted in amputation of finger;

— allegation of negligent treatment of orthopaedic injuries;

— alleged negligence in intubation resulting in neck/oesophageal injury;

— patient pregnant after second sterilisation;

— operation conducted on left knee instead of right knee;

— infant died as a result of lack of oxygen during transfer from one hospital to another;

— alleged negligence as a result of possible mishandling of blood for transfusion;

— alleged negligence after patient was admitted for pathology of the pancreas;

— alleged unnecessary operation during childbirth;

— during an operation to his foot, patient suffered burns necessitating amputation of a toe as a result of a faulty theatre light;

— depressed patient jumped from a hospital window resulting in paralysis. Claim for alleged negligence;

— second degree burns caused by a warming pad used on the patient;

— Premature discharge after a motor accident resulting in paralysis;

— tissue damage as a result of faulty placement of intravenous needle;

— alleged negligence as a result of Caesarean section. Wound failed to heal satisfactorily;

— incorrect removal of a salivary gland instead of a lymph gland;

— patient died due to internal haemorrhage.

(2) (a) *Minister of National Health and Population Development*,

(i) and (ii) no amount was paid over,

(b) *Administrators*,

Cape Provincial Administration,

(i) no,

(ii) Yes, 5 cases —
R2 500,00,
R2 500,00,
R4 000,00,
R20 000,00
and R185 000,00.

OFS Provincial Administration,

(i) no,

(ii) yes, 1 case — R450,00,

Transvaal Provincial Administration,

(i) yes, 1 case — R69 181,85,

(ii) yes, 4 cases —
R5 000,00,
R1 523 241,00,
R6 000,00
and R69,00,

Natal Provincial Administration,

(i) no,

(ii) yes, 3 cases —
R10 000,00
R4 500,00,
and R2 500,00.

Unused classrooms

481. Mr K M ANDREW asked the Minister of Education:

Whether there are any unused classrooms in any of the (a) farm, (b) other primary and (c) secondary schools falling under his Department; if so, how many in each of these categories in respect of each departmental region?

B1108E

The MINISTER OF EDUCATION:

Estimated number of unused classrooms in:

	(a)	(b)	(c)
Diamond Fields	20	28	3
Orange Vaal	42	21	0
Orange Free State	36	9	16
Cape	36	28	20
Natal	56	40	14
Northern Transvaal	55	58	0
Johannesburg	0	109	10
Highveld	53	70	7

Spare capacity for additional pupils

482. Mr K M ANDREW asked the Minister of Education:

Whether there is any spare capacity for additional pupils in any of the (a) farm, (b) other primary and (c) secondary schools falling under his Department; if so, how much in each of these categories in respect of each departmental region?

B1109E

The MINISTER OF EDUCATION:

Estimated number of unused places in:

	(a)	(b)	(c)
(i) Diamond Fields	1 789	2 325	894
(ii) Orange Vaal	7 152	2 525	0
(iii) Orange Free State	7 012	1 801	832
(iv) Cape	5 230	4 863	1 229
(v) Natal	6 733	3 425	1 956
(vi) Northern Transvaal	5 430	5 907	371
(vii) Johannesburg	0	13 244	2 664
(viii) Highveld	5 047	9 406	2 063

Stoffelton/Stepmore freehold complex

491. Mr W U NEL asked the Minister of Development Aid:

Whether, with reference to certain information that has been furnished to the Minister's Department for the purpose of his reply, it is the intention to hand over to KwaZulu any of the area collectively known as the Stoffelton/Stepmore freehold complex; if so, (a) which areas comprise the complex, (b) which areas are to be handed over, (c) how many persons are affected and (d) what progress has been made in this regard?

B1136E

The MINISTER OF DEVELOPMENT AID:

Yes, depending on the views of the inhabitants of the area.

(a) The areas which are defined in Schedule 1 to the Development Trust and Land Act, 1936 (Act 18 of 1936) as Areas No 14 and 16 (Natal).

(b) Approximately 1 500 hectares of Area No 14 forms part of KwaZulu, namely the farms Greenhill 8438, NE 2 — 14532, Bucklands 7508, Bucklands 5615, GR 19, Kilkenny and West Lynne No 2. The handing over of the rest of the area is subject to consultation with the inhabitants of the area and the Government of KwaZulu.

(c) Unknown.

(d) The matter has been referred to the Commission for Co-operation and Development for further consideration.

Walmer Township: secondary education

516. Lt-Gen R H D ROGERS asked the Minister of Education:

(1) (a) How many children requiring secondary schooling are there in Walmer Township, Port Elizabeth, and (b) how many pupils are there in Standards 4 and 5 in the primary school in this township;

(2) whether there are any plans to build a secondary school in this township; if so, when; if not; why not;

(3) whether there are any alternatives for children requiring secondary education in Walmer Township; if so, (a) what are these alternatives and (b) what is the estimated cost per pupil in each case;

(4) in respect of what date is this information furnished?

B1213E

The MINISTER OF EDUCATION:

(1) (a) It is unfortunately impossible to determine the exact number of children in Walmer Township in need of secondary schooling. At present there are 563 in the township who attend secondary schools.

(b) 369.

(2) Yes. A secondary school is envisaged. The planning of the school will receive attention as soon as a school site has been allocated to the Department.

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) With the information available in this regard, it is not possible to supply the costs of treatment or the reasons for differences at this stage;

(2) falls away.

Certain hospitals: in-patients

568. Mr L FUCHS asked the Minister of National Health and Population Development:

(1) How many in-patients can be treated daily at the (a) Baragwanath, (b) Johannesburg, (c) Hillbrow, (d) Natalspruit, (e) Leratong and (f) Tembisa Hospitals;

(2) in respect of each of these hospitals, how many (a) specialist posts are (i) offered and (ii) filled and (b) hours per week are worked by (i) nurses, (ii) interns and (iii) specialists;

(3) in respect of what date is this information furnished?

B1326E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Average number of in-patients per hospital per day:

(a)	Baragwanath Hospital	: 2 804
(b)	Johannesburg Hospital	: 774
(c)	Hillbrow Hospital	: 790
(d)	Natalspruit Hospital	: 804
(e)	Leratong Hospital	: 791
(f)	Tembisa Hospital	: 673

(2) (a) Number of specialist posts per hospital:

	(i) offered	(ii) filled
Baragwanath Hospital :	111	104
Johannesburg Hospital :	174	161
Hillbrow Hospital :	48	46
Natalspruit Hospital :	15	10
Leratong Hospital :	—	—
Tembisa Hospital :	14	13

(b) Minimum number of hours worked per week by:

(i) nurses	—	40 hours
(ii) interns	—	40 hours
(iii) specialists	—	40 hours,

(3) 1988/89.

Certain hospitals: maternity wards

569. Mr L FUCHS asked the Minister of National Health and Population Development:

(1) How many maternity wards are there at the (a) Baragwanath, (b) Johannesburg, (c) Hillbrow, (d) Natalspruit, (e) Leratong and (f) Tembisa Hospitals;

(2) (a) what is the (i) nurse/patient and (ii) intern/patient ratio at each of the above-mentioned hospitals, (b) what is the reason for any differences between such ratios in the case of each of these hospitals and (c) in respect of what date is this information furnished?

B1327E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Number of maternity wards:

(a)	Baragwanath Hospital	: 15
(b)	Johannesburg Hospital	: 7
(c)	Hillbrow Hospital	: None
(d)	Natalspruit Hospital	: 3
(e)	Leratong Hospital	: 2
(f)	Tembisa Hospital	: 1

(2) (a) (i) General nurse/patient ratio:

Baragwanath Hospital	: 1.4
Johannesburg Hospital	: 1.9
Hillbrow Hospital	: 1.2
Natalspruit Hospital	: 1.3
Leratong Hospital	: 1.0
Tembisa Hospital	: 1.2

(ii) General intern/patient ratio:

Baragwanath Hospital	: 0.02
Johannesburg Hospital	: 0.05
Hillbrow Hospital	: 0.04
Natalspruit Hospital	: 0.02
Leratong Hospital	: 0.0
Tembisa Hospital	: 0.03

(b) Differences in above-mentioned ratios are not statistically significant.

(c) 1988/89.

Medical/administrative staff

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

How many (a) medical and (b) administrative staff were employed by her Department as at 31 December 1989?

B1345E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) 98

(b) 694*

* this figure includes clerical personnel.

Doctors: car allowances

579. Mr G C ENGEL asked the Minister of National Health and Population Development:

(1) Whether (a) White, (b) Black, (c) Coloured and (d) Indian doctors in the employ of her Department receive car allowances; if so,

(2) whether these car allowances are the same for doctors of all race groups; if not, (a) in what respects and (b) why do they differ?

B1347E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes, allowances are payable in accordance with the motor finance scheme for senior officers and the subsidised transport scheme. Separate records are not kept per population group,

(2) yes.

Certain hospitals: budget for catering services

580. Mr G C ENGEL asked the Minister of National Health and Population Development:

(1) What was the budget for catering services at the (a) Baragwanath, (b) Johannesburg, (c) Hillbrow, (d) Natalspruit, (e) Leratong and (f) Tembisa Hospitals in the 1988-89 and 1989-90 financial years, respectively;

(2) whether food prices at such hospitals differ for patients and staff; if so, (a) in what respects and (b) why in each case;

(3) whether there has been any investigation into the possible privatisation of the catering services at these hospitals; if not, why not; if so, with what result;

(4) whether this investigation took into account the cost of (a) shrinkage, (b) wages, (c) illegal eaters and (d) cleaning services in such catering services; if not, why not; if so, with what result in each case?

B1348E

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Budget for catering services* for financial years

	1988/89		1989/90		
	Concept	Revised	Concept	Revised	
(a) Baragwanath	4 654 200	6 500 000	3 103 000	7 039 000	
(b) Johannesburg	3 833 700	4 500 000	4 634 000	6 286 000	
(c) Hillbrow	1 495 800	1 723 800	1 741 000	2 454 900	
(d) Natalspruit	1 411 700	1 715 000	1 949 000	1 949 000	
(e) Leratong and Paardekraal complex	1 750 700	1 751 000	1 921 000	1 326 600	(L)
				287 200	(P)
(f) Tembisa	883 300	1 052 600	969 000	969 000	

* Budget for food only.

(2) (a) and (b) the food cost per patient or staff member may differ depending on the specific eating pattern required.

Two types of eating patterns may be served in one hospital. That is a westernised and a non-westernised eating pattern. The nutritional content of both eating patterns meet the nutritional needs of both patients and personnel.

Research bodies turn to markets after fund cuts

85

P1 Dawn 25/6/90

CAPE TOWN — A reduction in state funding has forced research organisations like the Medical Research Council (MRC) into an entirely new role — the business of marketing their expertise to generate funds.

The new system of "base-line" funding merely keeps state grants in line with inflation with the result that, in real terms, total operating budgets often decline as many costs, particularly those of imported goods, tend to outgrow inflation.

This has placed serious constraints on research programmes, forcing research organisations to generate their own funds to supplement budget shortfalls.

George van Rensburg, chief executive director of the MRC, says the changes in funding have compelled his organisation not only to start marketing its existing expertise but also to continuously develop the marketable potential of a wide range of MRC-supported projects.

The MRC has launched its marketing efforts with the development of a locally manufactured monitor used in most hospitals.

"There is estimated demand for about 1 000 monitors annually. We hope to produce one which can be programmed for multi-purpose use at about half the imported price, and we are also thinking of exporting it," says Van Rensburg.

The MRC has established a small

LESLEY LAMBERT

company under the auspices of its development subsidiary, Medtech, to produce a prototype of the monitor, which it hopes to have tested by the end of this year. The company will then manufacture and distribute it.

Although a less risky income-raising exercise would be to market its expertise on a contract basis, the MRC recognises the value of establishing a track record in new business ventures so that it can attract venture capital to fund other long-term projects. However, it is aware of the risks attached to its new entrepreneurial role.

"Our business is medical research and we are not entering entrepreneurial partnerships and competitive markets because we want to."

"The MRC has established a long-term relationship and credibility within the medical fraternity. We do not want to harm our image in any way and want to execute our marketing efforts in an ethical and professional manner. The end objective is to generate additional income enabling the MRC to meet its commitments to SA's basic and long-term research needs, irrespective of the projects' marketability."

With this in mind, the MRC's strategy for the next decade is geared towards achieving a balance between short-term and long-term privatisation efforts and its basic mission as a research organisation.

ties and technikons.

The corporation's Central Training Unit — which employs about 50 professional

Unit, which aims to increase Anglo's and its associate companies' business transactions with the small-business sector.

Changing health threats will need new services — report

B1 Bday 29/6/90 (85) (288) (B)

CAPE TOWN — AIDS, assaults, smoking and alcohol-related diseases will replace diarrhoea and measles as major health threats in poorer communities during the next decade and dealing with them will require fundamental changes in health services.

This is the conclusion of a group of academic doctors in a recently published paper entitled Critical Issues for Community Health in the 1990s.

The authors argue that socio-political and demographic changes, particularly associated with high fertility rates and rapid urbanisation, will have a profound influence on the state of community health and

LESLEY LAMBERT

the provision of health care.

Another major influence will be the residual effects of apartheid which will remain for some time once the current race-based system has ended, they say.

To address the new health threats, fundamental changes will be required in the way community health professionals are trained, in the direction of medical research and the relationship between state health authorities at all levels and non-governmental organisations.

In addition, non-governmental organisations will be required to play an increasing role in extending and complementing the changing function of government health services.

The authors emphasise the need to address the private sector's tendency to treat conditions that produce maximum profit, while neglecting preventive, promotive and rehabilitative activities.

They accept that involvement in the less profitable activities will need to be compensated and that this may require a revision of medical aid benefits.

They welcome government and ANC announcements on the restructuring of health services with more emphasis on primary health care.

Star 26/7/90 (85)

Blood services: No race discrimination

The Highveld Blood Transfusion Services said yesterday that it had always been its firm policy not to practise racial discrimination either with regard to its donor population or the allocation of blood to patients.

In a statement, the HBTS noted it was concerned that recent reports regarding its policy and practice may have been misinterpreted by the public.

The statement did not specify the reports.

The HBTS furthermore noted it applied all the internationally recommended laboratory procedures to blood products in order to ensure acceptably safe blood to its patients.

Battery tests

These included tests for infection with either of the two strains of the Aids virus, carried out individually on each donated blood unit as part of a battery tests designed to exclude contamination with infectious agents recognised as blood transfusion risks.

The window period, when in rare instances blood may be infected with the Aids virus before the antibodies were detectable, was a cause for concern to all blood transfusion services and was receiving attention throughout the world, said the HBTS.

It also noted it was committed to using new technology to obviate the window period-related problems. — Sapa.

Star 26/7/90

Officials criticised over health issue

By Carina le Grange

The Conservative Party yesterday accused the "South African authorities" for being so sensitive towards criticism from the Black Health and Allied Workers' Union that it even threw healthy scientific principles overboard.

The CP's spokesman on health, Dr Willie Snyman, was responding to statements issued by the SA Blood Transfusion Service and the SA Institute of Medical Research that no racial discrimination was practised with regard to either the donor population or the allocation of blood to patients.

With the increases of heterosexual transmission of Aids one blood transfusion service recently ordered staff not to use blood from black and coloured donors. The union objected.

because of increasing JSE charges and the expense of developing infra-

Graphic: FIONA KRISCH Source: JSE

hold.

Norimed's float looks like a healthy winner

MARIETTE DU PLESSIS

NORIMED, which will be floated on the JSE via a reverse listing of Crest Holdings on August 6, is forecasting earnings of 87,8c a share in the year to end-June 1991.

The only operational business at the time of the listing will be that of Crest Healthcare, involving the manufacture, marketing and nationwide distribution of medical equipment to state and private hospitals, the company said in a statement released today.

Norimed, a health care company controlled by Noristan Holdings which is 21%-held by W & A Investment Corporation, has the backing of both.

This, together with R12,6m in cash and no borrowings, will enable it to finance further development of the Crest businesses and to expand Norimed's presence in the health care industry.

Three-million ordinary shares in Norimed, formerly known as Aurochs Investment company, will be listed in the pharmaceutical and medical sector of the JSE.

The company expects dividends of 29c a share for the current year and an attributable profit of R2,658m, before implementing any expansion moves.

(2) Nadat hy die akademiese kwalifikasie soos voorgeskryf in paragraaf 1 (1) verwerf het, minstens drie jaar aanvaarbare opleiding ontvang het, in 'n laboratorium of inrigting goedgekeur deur die beroepsraad en die raad: Met dien verstande dat, van die drie jaar opleiding by hierdie paragraaf voorgeskryf, sodanige applikant een jaar opleiding in die diskresie van die beroepsraad en die raad, kan ontvang het in die vorm van indiensopleiding terwyl hy ingeskryf was vir 'n honneurs- of hoër graad.

2. Ondanks andersluidende bepalings in hierdie reëls, is die raad geregtig om enige persoon wat nie ten volle aan die vereistes van hierdie reëls voldoen het nie, as biokinetikus te registreer, indien die beroepsraad en die raad na behoorlike ondersoek daarvan oortuig is dat sodanige persoon bevoeg is om as biokinetikus te praktiseer.

(3 Augustus 1990)

(2) Subsequent to having obtained the academic qualification prescribed in paragraph 1 (1), have had at least three years' acceptable training in a laboratory or institution approved by the professional board and the council: Provided that, of the three years' training prescribed in this paragraph, one year of training may, at the discretion of the professional board and the council, have been undergone in the form of inservice training while such applicant was enrolled for an honours or higher degree.

85

2. Notwithstanding anything to the contrary contained in these rules, it shall be lawful for the professional board and the council to register as a biokinetician any person who has not fully complied with these rules, if the professional board and the council, after due inquiry, is satisfied that such person is competent to practise as a biokinetician.

(3 August 1990)

RAADSKENNISGEWING 54 VAN 1990

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad vaardig hierby kragtens artikel 32 (1), gelees met artikel 61 (4), van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), die reëls vervat in die Bylae hiervan uit.

BYLAE

REËLS BETREFFENDE DIE REGISTRASIE VAN KLINIESE BIOCHEMICI

1. Die raad kan enige persoon wat die raad oortuig dat hy aan die vereistes uiteengesit in (1) en (2) hiervan voldoen, as 'n kliniese biochemikus registreer:

(1) Dat hy minstens 'n toepaslike magistergraad behaal het na die verwerwing van 'n honeursgraad, toegeken nadat hy deur 'n inrigting of eksaminerende liggaam wat van tyd tot tyd by besluit van die beroepsraad en die raad goedgekeur is as bevoeg om sodanige kwalifikasie toe te ken, geëksamineer is.

(2) Nadat hy die akademiese kwalifikasie soos voorgeskryf in paragraaf 1 (1) verwerf het, minstens drie jaar aanvaarbare opleiding ontvang het, in 'n laboratorium of inrigting goedgekeur deur die beroepsraad en die raad: Met dien verstande dat, van die drie jaar opleiding by hierdie paragraaf voorgeskryf, sodanige applikant een jaar opleiding in die diskresie van die beroepsraad en die raad, kan ontvang het in die vorm van indiensopleiding terwyl hy ingeskryf was vir 'n honneurs- of hoër graad.

2. Ondanks andersluidende bepalings in hierdie reëls, is die raad geregtig om enige persoon wat nie ten volle aan die vereistes van hierdie reëls voldoen het nie, as kliniese biochemikus te registreer, indien die beroepsraad en die raad na behoorlike ondersoek daarvan oortuig is dat sodanige persoon bevoeg is om as kliniese biochemikus te praktiseer.

(3 Augustus 1990)

BOARD NOTICE 54 OF 1990

85

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

The South African Medical and Dental Council hereby in terms of section 32 (1), read with section 61 (4), of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), makes the rules contained in the Schedule hereto.

SCHEDULE

RULES FOR THE REGISTRATION OF CLINICAL BIOCHEMISTS

1. The council may register as a clinical biochemist any person who satisfies the council that he has complied with the requirements set out in (1) and (2) hereof:

(1) That he has obtained at least a masters degree, following upon an honours degree, granted after examination by any institution or examining authority approved by resolution of the professional board and the council from time to time as competent to grant such qualification.

(2) Subsequent to having obtained the academic qualification prescribed in paragraph 1 (1), have had at least three years' acceptable training in a laboratory or institution approved by the professional board and the council: Provided that, of the three years' training prescribed in this paragraph, one year of training may, at the discretion of the professional board and the council, have been undergone in the form of inservice training while such applicant was enrolled for an honours or higher degree.

2. Notwithstanding anything to the contrary contained in these rules, it shall be lawful for the professional board and the council to register as a clinical biochemist any person who has not fully complied with these rules, if the professional board and the council, after due inquiry, is satisfied that such person is competent to practise as a clinical biochemist.

(8 August 1990)

RAADSKENNISGEWING 52 VAN 1990

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad vaardig hierby kragtens artikel 32 (1), gelees met artikel 61 (4), van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), die reëls vervat in die Bylae hiervan uit ter vervanging van die reëls afgekondig by Kennisgewing 34 van 1987.

BYLAE

REËLS BETREFFENDE DIE REGISTRASIE VAN MEDIESE WETENSKAPLIKES

1. Die raad kan enige persoon wat die raad oortuig dat hy aan die vereistes uiteengesit in (1) en (2) hiervan voldoen, as 'n mediese wetenskaplike registreer:

(1) Dat hy minstens 'n toepaslike honneursgraad behaal het na die verwerwing van 'n baccalaureusgraad, toegeken nadat hy deur 'n inrigting of eksaminerende liggaam wat van tyd tot tyd by besluit van die beroepsraad en die raad goedgekeur is as bevoeg om sodanige kwalifikasie toe te ken, geëksamineer is.

(2) Nadat hy die akademiese kwalifikasie soos voorgeskryf in paragraaf 1 (1) verwerf het, minstens drie jaar aanvaarbare opleiding ontvang het, in 'n laboratorium of inrigting goedgekeur deur die beroepsraad en die raad: Met dien verstande dat, van die drie jaar opleiding by hierdie paragraaf voorgeskryf, sodanige applikant een jaar opleiding in die diskresie van die beroepsraad en die raad, kan ontvang het in die vorm van indiensopleiding terwyl hy ingeskryf was vir 'n honneurs- of hoër graad.

2. Ondanks andersluidende bepalings in hierdie reëls, is die raad geregtig om enige persoon wat nie ten volle aan die vereistes van hierdie reëls voldoen het nie, as mediese wetenskaplike te registreer, indien die beroepsraad en die raad na behoorlike ondersoek daarvan oortuig is dat sodanige persoon bevoeg is om as mediese wetenskaplike te praktiseer.

(3 Augustus 1990)

BOARD NOTICE 52 OF 1990

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

The South African Medical and Dental Council hereby in terms of section 32 (1), read with section 61 (4), of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), makes the rules contained in the Schedule hereto in substitution for the rules published under Notice 34 of 1987.

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SCHEDULE

RULES FOR THE REGISTRATION OF MEDICAL SCIENTISTS

1. The council may register as a medical scientist any person who satisfies the council that he has complied with the requirements set out in (1) and (2) hereof:

(1) That he has obtained at least an honours degree, following upon a bachelor's degree, granted after examination by any institution or examining authority approved by resolution of the professional board and the council from time to time as competent to grant such qualification.

(2) Subsequent to having obtained the academic qualification prescribed in paragraph 1 (1), have had at least three years' acceptable training in a laboratory or institution approved by the professional board and the council: Provided that, of the three years' training prescribed in this paragraph, one year of training may, at the discretion of the professional board and the council, have been undergone in the form of inservice training while such applicant was enrolled for an honours or higher degree.

2. Notwithstanding anything to the contrary contained in these rules, it shall be lawful for the professional board and the council to register as a medical scientist any person who has not fully complied with these rules, if the professional board and the council, after due inquiry, is satisfied that such person is competent to practise as a medical scientist.

(3 August 1990)

RAADSKENNISGEWING 53 VAN 1990

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad vaardig hierby kragtens artikel 32 (1), gelees met artikel 61 (4), van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), die reëls vervat in die Bylae hiervan uit.

BYLAE

REËLS BETREFFENDE DIE REGISTRASIE VAN BIOKINETICI

1. Die raad kan enige persoon wat die raad oortuig dat hy aan die vereistes uiteengesit in (1) en (2) hiervan voldoen, as 'n biokinetikus registreer:

(1) Dat hy minstens 'n toepaslike honneursgraad behaal het na die verwerwing van 'n baccalaureusgraad, toegeken nadat hy deur 'n inrigting of eksaminerende liggaam wat van tyd tot tyd by besluit van die beroepsraad en die raad goedgekeur is as bevoeg om sodanige kwalifikasie toe te ken, geëksamineer is.

BOARD NOTICE 53 OF 1990

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

85

The South African Medical and Dental Council hereby in terms of section 32 (1), read with section 61 (4), of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), makes the rules contained in the Schedule hereto.

SCHEDULE

RULES FOR THE REGISTRATION OF BIOKINETICIANS

1. The council may register as a biokinetician any person who satisfies the council that he has complied with the requirements set out in (1) and (2) hereof:

(1) That he has obtained at least an honours degree, following upon a bachelor's degree, granted after examination by any institution or examining authority approved by resolution of the professional board and the council from time to time as competent to grant such qualification.

Township health in question

Star 13/8/90

By Carina le Grange,
Medical Reporter

The National Party-controlled management committee of Alberton is expected to discuss the future of health services for Thokoza township today, according to a municipal official.

It was reported last week that should the rent boycott in Thokoza continue, health services provided by the Alberton municipality could be cut off — a move that would affect between 150 000 to 250 000.

Thokoza administrator Gert Muller told The Star he was informed by an official of the health services of Alberton that the services would be suspended if Thokoza could not pay.

Empty coffers

"Thokoza has no source of income due to the boycott, and the coffers are empty," he said. "But the Alberton municipality is very sympathetic, however, and said they would see if they could get funds from somewhere — perhaps even the authorities — to deliver the necessary health services," Mr Muller said.

"Neither Alberton nor Thokoza want to curtail the services," he said.

The chief of Alberton's health services department, Andre Lotz said he understood the management committee would look at the matter at its meeting today.

Spokesmen for the management committee were not available for comment at the weekend.

Health care problems highlighted

Sowetan 14/8/90

WITH the possibility of a democratic South Africa emerging, a critical redress of the present health service will be necessary.

A National Health Service (NHS) based on the principles of primary health care and aimed at providing a comprehensive approach to health, including welfare and mental health, will be the best way to provide a non-discriminatory health care in a future South Africa.

This, in brief, is the summary of a workshop on a National Health Service for South Africa held earlier this year under the auspices of the Health Study Commission of the Transvaal region of the Centre for Development Studies.

Twenty health organisations were invited and most were represented. Among the delegates were Drs John Kalk, Joe Veriawa (convenors) Eric Buch, Melvyn Freeman, Nicky Padayachee and Tom Wilson (the working committee).

There are two major problems arising from the present health system the first of which is its historical record, shaped by segregation, fragmention and apartheid.

By ISMAIL LAGARDIEN

The consequences of the existing system is well known and resulted in "substantial wast of resources," Mr Cedric de Beer of the Centre for the Study of Health Policy at Wits Medical School said, outlining the problems with the present system.

"This occurs not only because of the duplication, indeed the multiple duplication, of administrative structures for the provision of health care, but also because there are substantial under-utilised resources which could be far more cost effectively used within a single planned health care service," De Beer said.

Curative

The private health care sector, he said, possibly consumes half of all the resources spent on health care while providing services for only a privileged few.

"This promotes and an extravagant form of curative care which leads to the expenditure of unneccessary resources which could be better used in providing care for those who need them.

"It undermines the public sector by attracting away doctors and nurses.

"Thus we have come to argue the case for a national health service with strong central control as the only way of undoing fragmentation, dismantling the effects of apartheid on our health care system, creating greater equality of access to health care and allowing for an effective process of planning and policy coordinating which is needed to achieve these goals," De Beer said.

But what exactly is a National Health Service?

The envisaged NHS should be controlled by the state with a view to ensuring that resources are allocated equitably and in such a way as to provide the best possible health care for all.

It can be assumed appropriate for the state to own the vast majority of health care facilities - meaning both hospitals clinics and community health centres - and that health care should be free at the point of service and paid for by the state.

Health workers, because of the aforementioned control, will be state employees paid on a salary basis.

This is currently the case with with doctors and nurses witin the public service.

Health doesn't have to mean wealth

By KATHY STRACHAN

THERE is no simple quick-fix to the problems of primary health care in South Africa, an international expert has said.

However, South Africa could learn much from countries in Africa as well as Central America and Asia, says Dr Gill Walt of the London School of Hygiene and Tropical Medicine.

"In lots of ways South Africa is unique because of the monster of apartheid," said South African-born Walt, who is visiting the country for the second time in 30 years. But she added that it does share a changing pattern of disease with other better-off Third World countries she has worked in.

"They share a transitional stage where there is a shift: where diseases such as malnutrition, infectious diseases and diarrhoea are the main causes of death — especially in children — to the chronic degenerative diseases of industrialised countries, such as heart diseases, cancer ... accidents," she said.

"South Africa will have to move towards a unified national health system. Looking after a particular racial group is not good for health."

She was encouraged by the way primary health care has taken off in South Africa in the last 10 years and attributed it to the awareness of alternative health groups to local health problems.

"The idea of the community health worker has been greatly influenced by the Chinese 'barefoot doctor'. People were excited that the community could choose someone among themselves to be trained and to return to the community to give health care."

An important lesson can be learnt from Cuba, which "took seriously the effects of other sectors on health. They built up water supplies, guaranteed a minimum amount of food for each person and reallocated resources from the capital, Havana, to the provinces in order to improve health."

Zimbabwe, she added, has also built up a successful primary health care network and found strategies to keep health workers in rural areas — a problem which South Africa also faces.

'Health must be ensured'

Star 30/8/90 By Louise Burgers

In terms of the Health Act governing the duties and powers of local authorities, municipalities which cut water and sewerage to townships could be breaking the law if unsanitary conditions develop.

A spokesman for the Johannesburg Health Department said a medical officer of health was responsible for ensuring the health of the population in his district. This meant the provision of adequate water and sewerage.

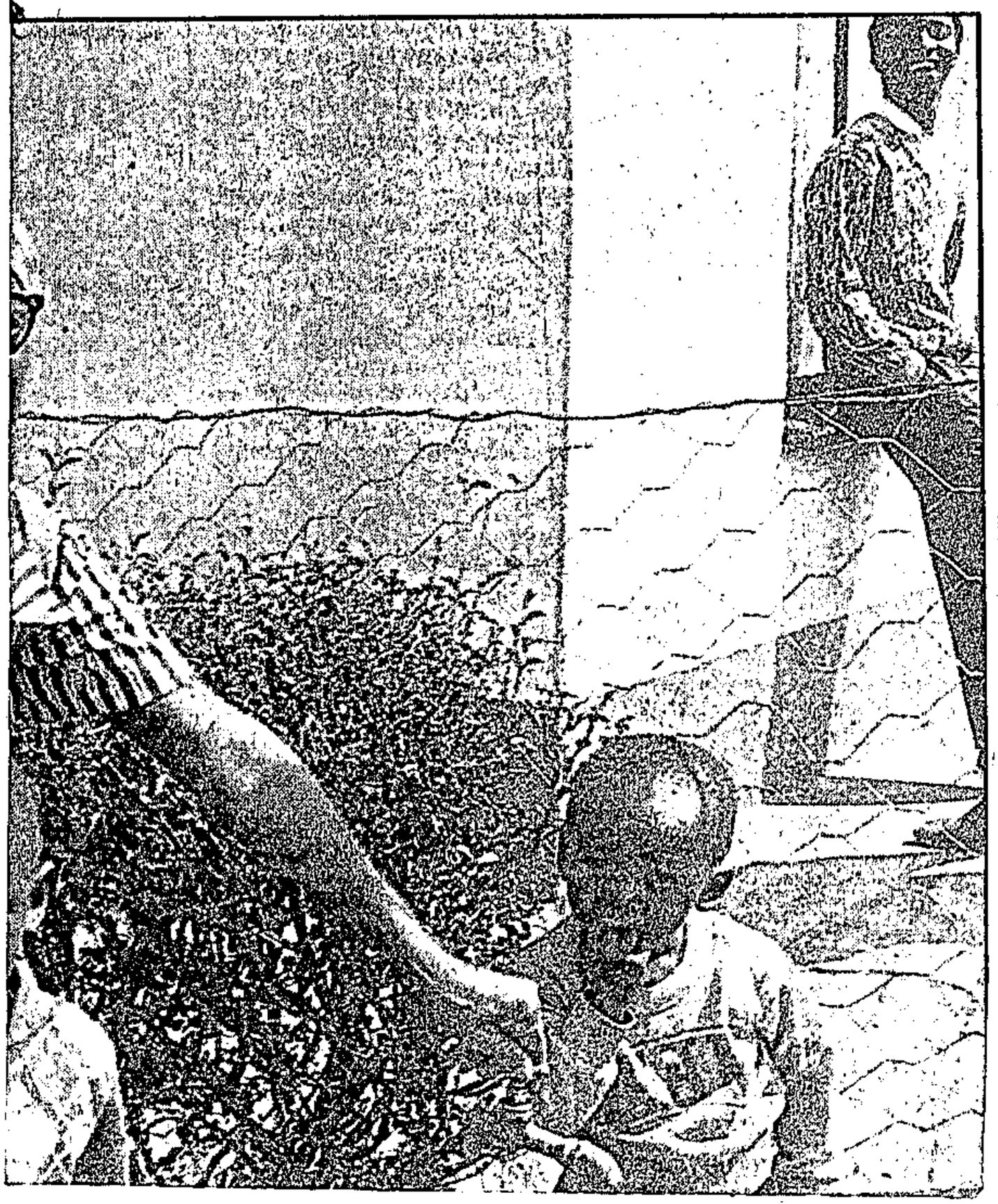
On Tuesday, Carolina's Conservative Party town council cut water, waterborne sewerage and electricity to the Silobela township because it was R25 000 in arrears.

Section 20 of the Local Authorities Health Act requires councils to maintain their districts at all times in a hygienic and clean condition.

The Transvaal Provincial Administration's director of liaison services, Piet Wilkens, said consumers had been warned of cuts if they did not pay their bills.

"Our bridging finance to assist boycott-hit black local authorities to pay their accounts and salaries is running out."

Mr Wilkens said he was sorry to hear that Carolina had cut services — "but people must pay for what they get".



A crisis is looming in medical technology

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Bl Day 14/9/92

THERE is a crisis looming in medical research, with cuts in expenditure that could see SA sliding into a Third World situation.

Medical Research Council president Dr Philip van Heerden says: "If this happens we will not recover."

He says there needs to be an integration of First World high-tech research to address Third World health problems.

"Research on both First and Third World health problems must be upheld and stimulated to prevent a downgrading of research leading to a dependence on assistance from other countries," he says.

The MRC has recently made a breakthrough in the identification of the genetic fault in familial hypercholeterolaemia, a genetic disease affecting one in 80 Afrikaners which causes premature heart attacks.

However, the health issues that are the priorities for medical research cover broader sweeps of the population.

Evaluation

Van Heerden says they are urbanisation and health; the evaluation of primary health care delivery systems; trauma and its impact on society; AIDS and malaria, particularly the epidemiological aspects of the two diseases; environmental health, focusing on air and water pollution and cardiovascular and cerebrovascular (stroke) diseases.

Rapid demographic and political changes have created an urgent need for community-based research to deal with the health problems emanating from increasing urbanisation.

The MRC, realising this need some years back, has shifted its research focus to deal with the health problems of urbanisation.

"Further financing is needed, especially for our research funding at the medical facilities because of the high costs of certain imported chemicals.

"Our research at cellular and molecular level does not get the financial support it should have, which is a tragedy," he says.

and SADF actions".

The commission also gave a break-down of detentions in SA, Transkei and Bophuthatswana.

domination and find an acceptable constitutional alternative.

"In these circumstances, who is going to maintain stability while the parties negotiate?" he asked.

year ago, "and particularly his actions since February 2, are a matter of public record and hardly need to be described again".

☐ The first protest against the Iron seven days, "failing which other forms of struggle will be resorted to".

ANC local official Baba Schalk declined to spell out the nature of these "other" actions. — Sapa.

Profuse praise for Rina Venter

B Day 24/9/90

TANIA LEVY

THE words "approachable" and "commended" cropped up repeatedly when health and welfare professionals were asked to comment on Health and Population Minister Rina Venter's first year in office last week.

Besides her obvious achievements such as opening hospitals to all races, Venter was seen to be an involved health minister with a clear desire to get primary health care to the whole population.

The medical profession lauded Venter's desegregation of hospitals and hoped sufficient funds would be made available to fully implement the decision, said Medical Association of SA (Masa) chairman Bernard Mandell.

The National Policy for Health Act introduced by Venter earlier this year to ensure a more effective, comprehensive health service was a positive step towards combating uneconomic fragmentation, said Mandell.

The five-point plan announced by Venter during the Budget debate in May intended to reconstruct the national health service, making it more accessible, affordable and effective.

Mandell said doctors had found Venter approachable and commended her ability to grasp the complexity of her portfolio.

Venter was given credit for playing a mediating role in the continuing battle between dispensing doctors and pharmacists.

She had not taken sides but had been firm about wanting the two sides to solve their differences in the interests of health care.

Pharmaceutical Society of SA (PSSA) president Tom Carse said that during the past six months Venter had facilitated meetings in which PSSA and Masa could thrash out their conflicting interests. He believed the two societies were coming to a solution which would be recommended to the Minister.

Prompt

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It was good to know that Venter's final decision would be impartial, he said. "She deserves applause for being enthusiatic and concerned about total health care for the whole population."

The PSSA welcomed her prompt action in speeding up the ban on skin lighteners last month, said Carse. Venter's predecessor, Willie van Niekerk, had been widely criticised for postponing the original June 1988 deadline to January 1991.

Pharmacists welcomed the control they would be able to exercise on skin lightening creams, which would no longer be sold as cosmetics but as medicines. Creams with less than 2% hydroquinone would be supplied at the pharmacist's discretion; those with more than 2% hydroquinone would require a doctor's prescription.

Johannesburg Child Welfare director Adele Thomas said Venter had to be commended for personally visiting unrest victims in hospitals and townships during past weeks.

Venter was easy to talk to and, as a social worker, understood welfare issues, Thomas said.

Her moves in terms of primary health care were very important. It was hoped that a similar approach to social welfare would be adopted. More grassroots community social work was needed in SA, rather than sophisticated First World services.

Thomas said Venter had to address the funding needs of welfare organisations, which were generally in dire financial straits.

Existing welfare policy, which entrenched inequalities, was a further area requiring critical attention. Venter had to push for a single state welfare system for all with parity in grants, subsidies and spocial pensions, said Thomas.

Bigger SAP 'wouldn't need tough laws'

B Day 24/9/90

GERALD REILLY

PRETORIA — A bigger, more professional and sophisticated police force would be less dependent on drastic legislation, Police Commissioner Johan van der Merwe said at the weekend.

Speaking at a human rights conference at Unisa, Van der Merwe emphasised public order — an absence of riots, insurrection and violence — could be maintained effectively only if police had adequate equipment and manpower.

He said a charter of human rights would force the police to adjust their approach in certain aspects of policing. With "terrorists" ordinary methods of detention and apprehension had to apply as far as possible.

Human rights, whether guaranteed by a charter or not, could not be absolute or unlimited. A charter had to be balanced between the rights of individuals, the community and the state.

HEALTH

BREAKING POINT

Health Minister Rina Venter and her colleagues responsible for health in Natal and KwaZulu can't say they weren't warned. Since the beginning of this year, there have been clear signals that the region's overburdened, understaffed hospitals were about to crack.

The recent nurses' strikes at two hospitals in Natal, officially "KwaZulu hospitals" under the fragmented, 14-department health system, were only the most obvious symptoms presented.

The strikes — at Umlazi's Prince Mshiyeni and Maritzburg's Edendale hospitals — placed an intolerable burden on Natal's provincial hospitals and cost the provincial administration something like R11m in trying to cope with transferred patients.

Unless funds are received from Venter's department soon, at least one institution could actually close down. Natal's major teaching hospital, King Edward VIII, needs an immediate injection of R18m just to keep running until the end of the year. An additional R42m is needed to keep other hospitals running at present capacity and Durban's Addington Hospital will have to close more wards unless it gets help (five wards are already closed).

The provincial ambulance service needs a R12m boost. Ambulance chief John Keenan says if funds are not received soon, response time could drop by 50%, 160 paramedics and admin staff face retrenchment and, at worst, the service could be forced to close down by the beginning of November.

Incredibly, no commitment has come from Venter. Besides improved working conditions and awarding salary increases to KwaZulu nurses who went on strike, the only other outcome was a promise from Venter to meet Natal's provincial executive committee member in charge of health, Peter Miller, next month.

Her office said this week that Venter was not prepared to comment further on the health crises in Natal, except to say that R12m in additional funds had been forwarded for health services in SA and that *some* of it might be allocated to Natal.

Miller, whose hands are tied in providing finances, did however make some insensitive comments after the nurses' strikes had ended, accusing the nurses of "disgraceful conduct" and of acting like "a bunch of coal miners."

When nurses include in their list of grievances, apart from pay, the fact that security and the state of hospital lighting is so bad that they are being raped and mugged on the premises, something is badly wrong.

Besides, the strikes were a long time coming. At a two-day national nursing conference in February this year (*Current Affairs* February 9) nurses pleaded for improvements to their profession, sending a memorandum to Venter highlighting the poor conditions they were forced to work under.

Only weeks later, Democratic Party health spokesman Mike Ellis warned that nurses were in a militant mood and that strike action might be the only way of making their plight public (*Current Affairs* February 23). Nothing was done, so the nurses' strikes should not have come as a surprise.

Ellis says that while nurses' apparent attitude while on strike (toyi-toying in front of TV cameras) cannot be condoned and that it is "unforgivable" that their action led to the deaths of some patients, if they did have real grievances which were not being addressed or even listened to "then some form of organised strike action may well have been necessary" to get the attention of the authorities.

"Until a single health ministry exists with a proper devolution of authority to regions — and regions based on geographic lines, not race — we will never overcome the problems we have," Ellis says.

Nobody expects the State to be a bottomless pit of finance, even in essential areas like health. But, when nurses see, and protest against, an expensive, top-heavy, over-administered national health structure made up of 14 different departments (with five different departments controlling hospitals in the Natal-KwaZulu region alone), it's hard to blame them for going on strike.

Venter ... *no commitment from her*

There are indications that the Natal health crisis is only an extreme reflection of the situation in the rest of the country. It is remarkable that a government which has admitted the failure of its homeland policy is unable to take the administrative measures required to enable the situation on the ground to catch up with the new thinking.

It is not only in administration that duplication of services is evident. When there are labour problems, as any manager knows, a coherent and sensitive response is required. And when management is diffused along discredited racial lines, unsure about responsibilities, buck-passing becomes endemic.

would affect the economy | disease would decimate the | create power vacuum

Masa submits a model for unitary health care system

B 10 am 11/10/90

GERALD REILLY

PRETORIA — A unitary health care system with one Health Ministry supported by a health advisory council is one of two major proposals in a model for academic medicine submitted to the National Health and Population Development Department.

The submission, by the Medical Association of SA (Masa), also provides for greater managerial autonomy at hospitals.

The submission follows a recent summit on the future of academic medicine.

Masa secretary-general Hendrik Hanekom said real changes had to be made in the current health delivery service.

The model anticipates major restructuring, particularly at central government and provincial administration levels.

It was drawn up by a firm of management consultants.

An ideal system would allocate health services to each level of the health system.

Important too would be involvement in and encouragement of other socio-economic measures aimed at improved health status for all.

The model provides for the country to be divided into "academic complexes", each centred around a university and including facilities for meeting the training needs of universities.

This would ensure teaching took place at tertiary, secondary and primary health care levels.

Seven complexes are suggested in the model — surrounding the Universities of Cape Town, Stellenbosch, Free State, Natal, Witwatersrand, Pretoria and Medunsa.

Other areas would be served by regional health boards.

Neither the boards nor the complexes would follow provincial boundaries.

Chief executive officers — not necessarily doctors — would be appointed to each academic complex, board and hospital.

The model also provides for access by patients to the level of treatment needed and academic hospital admissions would be on a referral basis only.

Call to unify SA health services

CAPE TIMES 5/10/89

Staff Reporter

HEALTH services in South Africa should not be fragmented into "20 or 30 sub-divisions" but unified in one central health service, the secretary of the Public Servants League of SA said yesterday.

Addressing about 200 Tygerberg Hospital workers, Mr Bernard Wentzel said 70% to 80% of the South African population were dependent on state health services which are administered by various state departments.

"Are we busy sub-dividing SA or building unity?" he asked. He called for a "living wage" for hospital workers and said to loud applause that government was "handing out money to independent countries".

Cape Provincial Administration director of hospital services Dr George Watermeyer told the workers that although there was a new movement towards privatisation, the state would still stay responsible for a large part of health care in the country.

He said the aim of the private sector was to make profit whereas government was committed to "delivering service" to the public.

6/10/89 FMail

Cutting costs

The health-care sector could be revolutionised by the recent launch of a health maintenance organisation by a major medical aid administrator.

After three years of research Medicaid Administrators has started the Managed Healthcare Plan which it claims will reduce costs while maintaining the quality of health care.

Medicaid executive director Quentin Robinson says the scheme is aimed at low-income groups who find conventional medical aid less and less affordable. In four years, for example, medical aid contributions could be costing blacks between 17% and 25% of their wages.

The scheme's administrators will charge a monthly subscription fee that will cover each member's entire health care needs. They hope eventually to enrol 30 000 members. Break-even point is put at 12 000.

A clinic will be built on the outskirts of a major black township. Several sites are under consideration. It will concentrate on preventive care programmes, such as health education, mother care, oral hygiene and immunisation, but also provide treatment and a 24-hour emergency service. To cut costs many routine medical procedures will be carried out by nurses instead of doctors. Subscription fees will be the only source of income so the operators have nothing to gain from over-servicing — in sharp contrast to the medical aid system.

John Cowlin, the plan's medical director, says the major advantage of facilities like these is that they provide primary health care services in communities where they are scarce. "At this stage blacks may be paying medical aid subscriptions but don't have any facilities they can use anywhere near where they live."

The 1987 Browne Commission into health care and medical costs recommended that alternative delivery systems, such as health maintenance organisations, should be encouraged to reduce costs. Medicaid's announcement has not, however, been greeted with universal approval in the health care field.

Clinic Holdings chairman Barney Hurwitz warns these schemes amount to group practice which the ethical rules of the profession prohibit. "It's in the interest of practitioners to create work for each other. It is more expensive in the long run than the present system of free choice."

The Medical Association, which represents doctors, is nonetheless softening its stance on health maintenance organisations. The association has always opposed them, arguing they restrict free choice of doctors and, because they emphasise cost-containment could lead to declining standards. Its incoming director-general, Hendrik Hanekom, says the association is still weighing the pros and cons of health maintenance organisations. ■

Iday, October 18 1990

Nationalising 'will ruin health care'

BDay 18/10/90

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THE country's health-care system would be crippled if nationalisation and redistribution were to form part of SA's economic policy, pharmaceutical manufacturer Noristan chairman Niko Stutterheim said in a statement yesterday.

He warned against economic policy changes which would cut SA off from health-care technology abroad.

"Nationalisation and an imposed redistribution of wealth, as advocated by some quarters as part of their desired scenario for SA, would lead to further disinvestment and could eventually cut us off from the sources of technology on which health care greatly depends."

Stutterheim stressed the importance of an overall policy based on consultation, co-operation and a sound information base, because government resources alone would not provide adequate care for all.

Therefore an efficient and affordable policy which drew on the resources of the state, the pharmaceutical industry, private clinics and hospitals, the pharmacists, dispensing doctors, medical aids and nursing

MARIETTE DU PLESSIS

services was of utmost importance.

He said the benefits of technology transfer and developments in pharmaceuticals and medical equipment had provided tremendous productivity benefits in recent decades, such as short recovery times after operations and illnesses.

Imbalance

It was clear from expenditure on health care as a percentage of GNP, birth rates, life expectancy and mortality rates, that SA's health services compared reasonably well with those of African and developing countries' standards, Stutterheim said.

However, there was an imbalance between the level of expenditure on curative medicine compared with spending on preventative care.

Only through early diagnosis and disease prevention, could expensive and sophisticated health services be applied where they were most needed, improving the general health level of the population in an effective manner, he said.

$8bn debt rescheduled

Stals averts debt crisis

Capt Times 19/10/89 8

Own Correspondent

JOHANNESBURG. — Reserve Bank Governor Chris Stals averted a foreign debt crisis next year by nailing down a payment schedule on $8bn debt falling due in June 1990.

SA's chief debt negotiator yesterday unveiled the details of the Third Interim Arrangements — a schedule of payments SA can meet without sinking into a recession.

In spite of intense political pressure on SA's foreign creditors to demand larger instalments, the new agreement is effectively an extension of the previous one.

In terms of the agreement, SA will repay $1,5bn over three years and six months — 20,5% of the $8bn caught inside the standstill net. This amount will be repaid in eight instalments varying in size, starting in December 1990.

Stals said last night: "I am relieved we no longer face a crisis in June next year, but this does not mean there is less pressure on the balance of payments (BoP).

"We will meet our new commitments as we did the previous ones — with difficulty. Economic policy will have to remain restrictive, especially considering the large payments of debt outside the net falling due next year."

The Reserve Bank Governor negotiated a neat package which takes account of maturities of foreign debt outside the net.

Instalments on affected debt are smaller in periods when debt outside the net is a major source of pressure on the capital account of the (BoP).

The agreement further takes account of the maturity structure of SA's debt through changes to the provision for converting loans inside the net to longer term loans outside the net.

Next year will be especially difficult with about $2bn falling due outside the net in the first half of the year. But Stals points out that the instalment on debt inside the net was deliberately kept small to take account of this, adding only about $100m to total foreign debt payments next year.

This is followed by the following instalments: February 1991 (2,5% of the total capital), August 1991 (3%), February 1992 (3%), August 1992 (3%), February 1993 (3%), August 1993 (3%) and in December (1,5%).

Foreign creditors retain the option to convert debt inside the net to longer term loans outside the net, but the terms have changed in a way that favours SA.

Stals said the first instalments of conversions in terms of the new agreement only fall due in 1998 — the beginning of a period in which SA's existing foreign liabilities are negligible.

"We already faced substantial liabilities up to 1997 and it was prudent to avoid more pressure in this period. The repayment of these loans will be bunched in three years — beginning in 1998."

The loans will be treated as follows: From July 1, 1990 to December 31, 1993, payments will be as for debt inside the net — followed by a period of no redemption from January 1, 1994 until 7½ years after the original date of conversion. The balance will be paid in the final 2½ years in six equal half-yearly instalments.

Stals's statement said the Third Interim Arrangements were arrived at after extensive discussions between members of the SA Standstill co-ordinating Committee and "many of the major foreign creditors".

The current economic situation in SA was analysed and prospects for the SA BoP over the next four years were discussed.

The statement said further details of the new arrangements would be conveyed to all SA's foreign creditors soon and the arrangement would also be applied to all foreign non-bank creditors holding part of the affected indebtedness.

'Health-care costs set to rise R800m' — Rams

CM+ Times 28/10/89

JOHANNESBURG. — South African medical schemes are gravely concerned about the continued escalation in private health care costs funded by medical schemes which, according to the Representative Association of Medical Schemes (Rams), are set to rise by about R800 million in 1990.

In a statement yesterday, Rams said it had made this forecast after consultations — in terms of the Medical Schemes Act — with suppliers of health-care services, to determine statutory scales of benefits for 1990.

Rams executive director Mr Rob Speedie said the Medical Association of South Africa (Masa) had effected a number of very significant adjustments to the relative values of certain services since Rams published its 1989 scale of benefits.

"Rams is to increase the payout by medical schemes for 1990 by 15%. To this must be added the impact of ever-increasing use of medical services, which is expected to contribute another five percent to costs next year, as it has done over the past few years.

"So the total increase in payout by schemes for medical services is expected to rise by 20% in 1990, before any possible upward adjustment to the monetary value of services is considered," he explained.

He said the Masa adjustments would have the biggest impact on the less privileged medical scheme members, since Masa's latest tariffs favour the general practitioner, with whom black and coloured people consult the most. So much so that more than 50% of the costs of some schemes providing for this section of the community were for general practitioner services, he added. — Sapa

Medical watchdog not watching drips scandal

By PAT SIDLEY (85) (90) W/Mail 26/10 - 1/11/90

THE Medicine Control Council, the state's watchdog on drugs and pharmaceutical products, is not investigating Sabax, the company which manufactures intravenous drips allegedly linked to the deaths of babies in the Transvaal.

This was confirmed by the MCC's head, Professor Peter Folb.

At least two dozen newborn babies have died in Witwatersrand clinics and hospitals after being infected by the Klebsiella bacteria which, the Park Lane Clinic alleges, was carried in the intravenous drip bags fed into the children in the clinic's neo-natal intensive care ward.

Several doctors said the factory should have been closed and the products recalled. However, millions of rands are at stake, Sabax is the major producer of the bags and it is the only producer of certain products.

The Transvaal Provincial Administration said it is to investigate the recent deaths, but it now seems that a judicial commission of inquiry will be appointed by the government.

The MCC sees to it that drugs, drips and other pharmaceutical products do the job they claim to do, safely and efficaciously. If there is any doubt, thorough investigations are carried out by the MCC inspectorate, said Folb. And no license is granted before the facility is inspected, without warning.

It is not clear whether the drip bags contained the same fluid, or even whether the original component was a fluid or had been mixed from a powder. It is also unclear where the mixing took place — if there was any mixing.

It appears that some products are manufactured by Sabax and the seal is not broken until the drip is placed in the patient. However, at many facilities, including the Johannesburg and Coronation hospitals, the contents of the drips are often mixed at the hospital's dispensary or in the ward.

According to one doctor, a procedure to prevent infections is followed. This includes taking a swab and culturing it every time a drip is inserted in a baby and changed or mixed. The drip site is changed every 48 hours, as this is the primary cause of infections. If this procedure was followed, then any trace of Klebsiella ought to have been picked up.

According to the Park Lane Clinic, the bags are mixed at Sabax according to doctor's prescriptions and sent intact to the clinic. Sabax has been reported as agreeing with this version.

Senior department of health sources drew a distinction between the dispensing of the product and its manufacture, saying they believed it to be a dispensing problem in this case. Dispensing implies that a mixture has been created according to a doctor's prescription.

●The lawyer representing the babies' families, doctors and some government health officials are calling for an independent inquiry.

Govt probes spill warning

Sewage pouring into rivers

SUE OLSWANG and SAPA

HEALTH Minister Rina Venter is investigating warnings of a serious health threat from sewage-polluted streams in the Witwatersrand, her department confirmed yesterday.

Dr Venter is expected to release a statement on the issue soon.

At least four Highveld rivers are being threatened by a serious health crisis because sewage is pouring into the rivers from nearby black townships.

An official at the Department of Water Affairs in Pretoria told Saturday Star his department has identified sewage spillover problems in the Blesbokspruit, the Natalspruit, the Klip River and the Rietspruit.

Defective

He said sewage spillovers into the rivers were being caused by inadequate sewage systems, blocked sewers and defective sewage pumps in nearby black towns.

"The only way to solve the problem is to provide financial assistance for new sewage systems and the opening of sewers," he said.

"The sewage spillovers represent a serious health hazard to township residents but will not harm fish and other river life unless there is a depletion of oxygen levels."

The official said pollution in the Blesbokspruit and Natalspruit will, to some extent, be countered naturally because an abundance of vegetation will help in the self-purification process.

He said it was doubtful whether any of the rivers would be permanently damaged by the sewage spillovers.

Meanwhile, leading virologist Professor Margaretha Isaacson of the South African Institute for Medical Research, yesterday added her voice to the warnings.

Cholera

Usage of untreated, sewage-polluted water could cause serious outbreaks of cholera, typhoid, polio, hepatitis, dysentry and gastro-enteritis — and raw vegetables such as carrots and lettuce, irrigated with such polluted water, could pose a health threat to the population at large, she cautioned.

However, the Health Ministry's epi demiology director, Mr Horst Kustner, said yesterday the health risks posed by the polluted water only faced people who used river water in its untreated form.

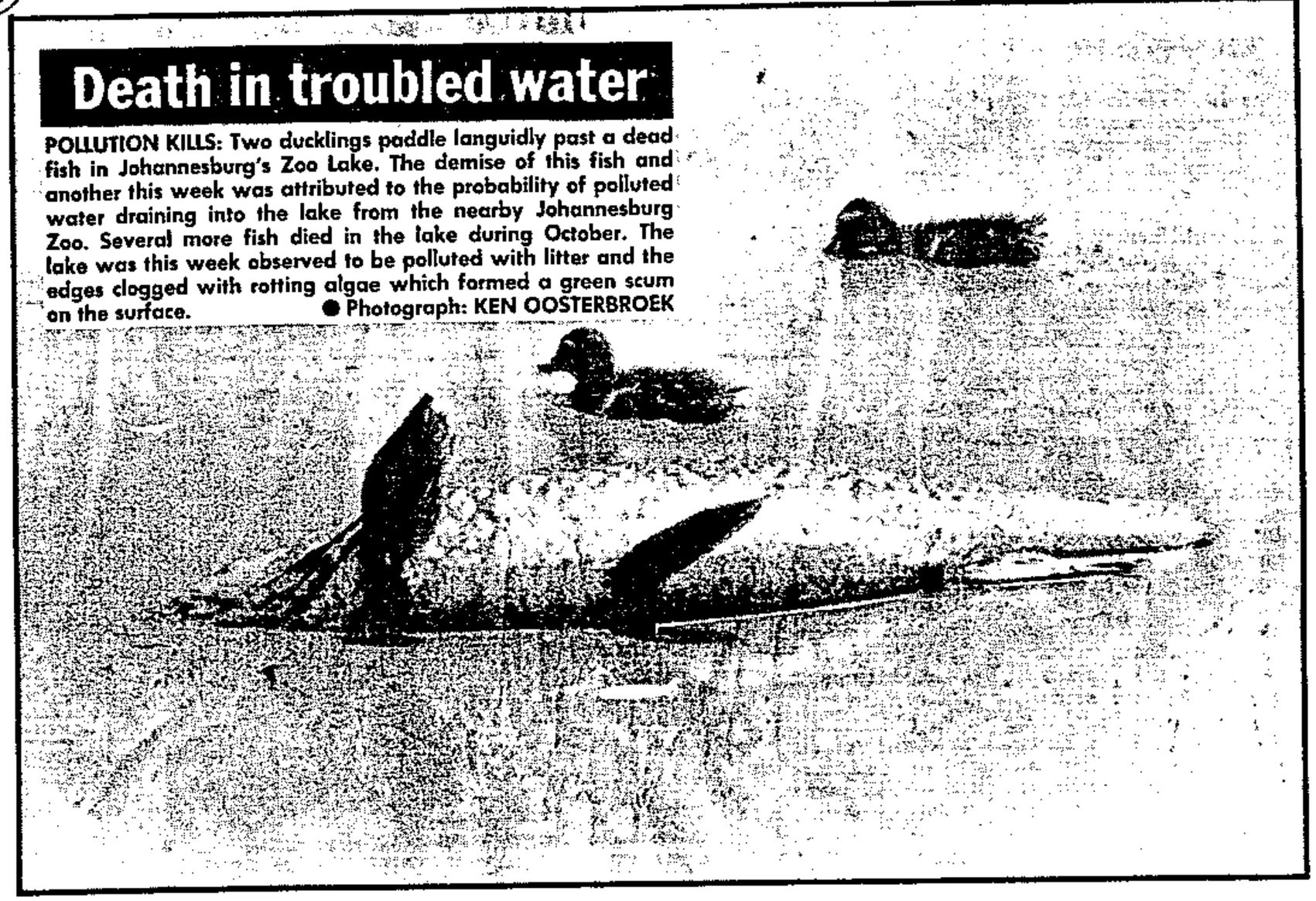
He told SABC radio news the water supplied to cities, townships and farmlands through which the affected rivers ran was treated and totally safe.

Mrs Maria d'Oliveira, deputy director of the Department of Water Affairs' Highveld water quality division, who earlier released news of the potential hazard, told Sapa her on-site inspection yesterday morning had again found a great deal of raw sewage in the Klip River near Soweto.

She has alerted the Department of Health in Pretoria about the health threat, posed especially to the squatter communities who use untreated water from the streams.

Department of Health Services and Welfare spokesman Mr Johan van Niekerk said the Director General was also giving urgent attention to the problem.

Death in troubled water



POLLUTION KILLS: Two ducklings paddle languidly past a dead fish in Johannesburg's Zoo Lake. The demise of this fish and another this week was attributed to the probability of polluted water draining into the lake from the nearby Johannesburg Zoo. Several more fish died in the lake during October. The lake was this week observed to be polluted with litter and the edges clogged with rotting algae which formed a green scum on the surface. ● Photograph: KEN OOSTERBROEK

Daveyton residents organise clean-up

STAN HLOPE

THE Daveyton Interim Committee (DIC), the newly-formed Daveyton Health Committee and the town's Sayco branch have launched a two-day clean-up campaign to start today.

Tour

The media was taken on a tour of the East Rand township by the DIC executive committee and former mayor Tom Boya, and saw rubbish in front of shops, schools, nurseries and churches. Rivulets of sewage flowed along the streets.

A refuse company and coal merchants have offered their trucks and graders.

DTA back after walkout

WINDHOEK — Members of the Democratic Turnhalle Alliance were back in the Namibian National Assembly yesterday after walking out on Thursday when government members voted down an attempt by DTA chairman Dirk Mudge to introduce a motion on economic policy.

Two members of Action Christian National, Mr Jan de Wet and Mr Peter Kayser, joined the walk-out.

Mr Mudge afterwards claimed the Swapo government was violating the freedom of speech provision in Namibia's Bill of fundamental rights, which indicated the government would decide what opposition parties should say in public.

But Prime Minister Hage Geingob said the DTA and ACN walk-out was not caused by the government's view on the discussion of economic policy, but because the opposition could not accept democratic defeat.

Opposing the introduction of the motion, Mr Geingob said the Namibian government was presently engaged in bilateral negotiations on trade with several foreign governments.

Once definite conclusions and agreements had been reached, NA members would have the opportunity to debate the issues.

The Prime Minister said an investment code was presently being drafted by Namibia and would be tabled for discussion in the NA in due course.

The DTA and ACN walk-out left the assembly without a quorum and business was suspended until Friday. — Sapa.

Give us immunity, say draft-dodgers

MIKE SILUMA

LONDON — Ten exiled conscientious objectors due to return to South Africa this month have called on the Government to end conscription and guarantee the safe return of all exiles.

The 10, who have lived abroad for periods ranging from a year to 11 years, said the abolition of conscription would encourage the return of other exiled resisters.

In a joint statement the group said: "We are returning with no guaran-

To be accompanied by their friends and families, the 10 will leave Britain for South Africa on November 30.

The Committee on South African War Resistance (Cosawr), which has represented the interests of exiled war resisters since 1979, said the return of the group would mark the end of its operations in Britain and Holland.

Cosawr said up to

Sewage poses health hazard in Daveyton

By Helen Grange and Abel Mushi

Streams of sewage in the East Rand's Daveyton township, where inadequate sewerage pipes have overflowed, are threatening to enter the nearby Blesbok River.

The situation has created a health hazard for Daveyton and prompted the East Rand Regional Services Council (RSC) to build another pipeline which would direct the overflow into Benoni's sewerage system.

But Benoni Town Council has refused to have the new pipe connected until it can forge an agreement whereby the operation costs can be paid for.

Shared

"Daveyton Town Council is strapped for money and obviously won't be able to contribute to the service," said Benoni town clerk Deneys Conradie.

"We can't simply charge our white ratepayers more for a sewerage system that is shared."

The RSC was prepared to maintain the pipeline until March.

Mr Conradie said Daveyton's sewerage system could not handle effluent from its growing population.

Daveyton council had received no money from rates to service chemical toilets in the squatter areas or to pay for refuse removal.

"It is an unholy mess," Mr Conradie said.

Residents in the Shangaan section of the township said they had lived with sewage filth for 13 years.

Families told The Star they had become tired of reporting the matter to the council.

"I moved to this house in 1973, and from 1977 we started having problems with blocked drains and toilets," said Mita Mothisi of Phaswane Street.

"Sewage overflows about three times a month from the toilet and we are tired of reporting it to the council.

"The only thing they do is unblock the drains and leave, but the problem never stops.

"And how can one sleep well when it smells so badly throughout the house?" she asked.

Joyce Lubisi of Phambani Street said she suspected that her children frequently became ill because of the unhygienic conditions caused by the sewage spillage.

Earthlife spokesman Henk Coetzee said the organisation was "keeping an eye" on water near several townships where pollution was heavy.

There was a need to control domestic and industrial pollution which flowed into streams and rivers, he said.

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Star pg 13/11/90

The Star Tu

River sewage warning

By Shirley Woodgate

The Department of Water Affairs is considering taking legal action against black municipalities which are allowing raw sewage to overflow into tributaries of the Vaal River.

This follows the build-up of sewage which is overflowing into the rivers after pumps at certain townships were shut down following non-payment of electricity bills.

Health Department spokesman Karen Knobel said her office would come into the picture only if the situation were considered dangerous, and that people on the affected streams were not dependent on river water for their daily supply.

But SA Institute for Medical Reseach virologist Margareta Isaacson warned that cholera, typhoid, polio, hepatitis, dysentery and gastro-enteritis could be caused by untreated polluted water.

Meanwhile the Rand Water Board has stated emphatically that pollution which might be caused by the raw sewage flowing into the river system poses no health hazard in the PWV area.

"There is absolutely no indication of pollution in the water supplied by the RWB to the PWV area," said RWB pollution control officer Ray Haynes.

"The origin of the raw sewage on the East Rand is a long way from the Vaal Barrage, 80 km downstream from the Vaal Dam.

The Suikerbos and Blesbok rivers, which are at risk, are low and farmers are irrigating extensively from these streams, so that there is little flow into the Barrage, Mr Haynes said.

RWB chief scientist Chris Viljoen warned people who used the Barrage for boating and skiing that there was always risk involved in using dams.

No. R. 2784 **30 November 1990**

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

PROFESSIONAL BOARD FOR MEDICAL SCIENCE

In terms of section 15 (4) read with section 61 (4) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), I, Elizabeth Hendrina Venter, Minister of National Health and of Health Services: House of Assembly, hereby amend Government Notice No. R. 1736 of 9 August 1985 to the extent that the Professional Board for Medical Science established thereunder shall, with effect from 30 November 1990 consist also of persons whose names appear on the register of clinical biochemists and biokineticians.

E. H. VENTER,

Minister of National Health and of Health Services: House of Assembly.

No. R. 2785 **30 November 1990**

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

REGULATIONS RELATING TO THE CONSTITUTION, FUNCTIONS, POWERS AND DUTIES OF THE PROFESSIONAL BOARD FOR MEDICAL SCIENCE

The Minister of National Health and of Health Services: House of Assembly has, in terms of section 15 (5) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), made the regulations set out in the Schedule hereto.

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 and, unless the context otherwise indicates—

"member" means a member of the Professional Board for Medical Science;

"professional board" means the Professional Board for Medical Science established in terms of section 15 (4);

"section" means a section of the Act.

CONSTITUTION OF THE PROFESSIONAL BOARD

2. The professional board shall consist of 11 members and shall comprise—

(a) two persons designated in terms of section 15 (6) (a) and (c); and

(b) three persons that are registered medical scientists, elected to be members by the persons whose names appear in the register of medical scientists kept under section 32; and

No. R. 2784 **30 November 1990**

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

BEROEPSRAAD VIR MEDIESE WETENSKAP

Kragtens artikel 15 (4) gelees met artikel 61 (4) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), wysig ek, Elizabeth Hendrina Venter, Minister van Nasionale Gesondheid en van Gesondheidsdienste: Volksraad, hierby Goewermentskennisgewing No. R. 1736 van 9 Augustus 1985 dermate dat die Beroepsraad vir Mediese Wetenskap wat daarby ingestel is, met ingang van 30 November 1990 ook bestaan uit persone wie se name op die register van kliniese biochemici en biokinetici verskyn.

E. H. VENTER,

Minister van Nasionale Gesondheid en van Gesondheidsdienste: Volksraad.

No. R. 2785 **30 November 1990**

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

REGULASIES BETREFFENDE DIE SAMESTELLING, WERKSAAMHEDE, BEVOEGDHEDE EN PLIGTE VAN DIE BEROEPSRAAD VIR MEDIESE WETENSKAP

Die Minister van Nasionale Gesondheid en van Gesondheidsdienste: Volksraad het kragtens artikel 15 (5) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), die regulasies in die bylae hiervan uiteengesit, uitgevaardig.

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 en, tensy uit die samehang anders blyk, beteken—

"artikel" 'n artikel van die Wet;

"beroepsraad" die Beroepsraad vir Mediese Wetenskap ingestel kragtens artikel 15 (4);

"lid" 'n lid van die Beroepsraad vir Mediese Wetenskap.

SAMESTELLING VAN DIE BEROEPSRAAD

2. Die beroepsraad bestaan uit 11 lede saamgestel uit—

(a) twee persone aangewys kragtens artikel 15 (6) (a) en (c); en

(b) drie persone wat geregistreerde mediese wetenskaplikes is, as lede verkies deur die persone wie se name verskyn in die register van mediese wetenskaplikes wat ingevolge artikel 32 gehou word; en

(c) two persons that are registered medical physicists, elected to be members by the persons whose names appear in the register of medical physicists kept under section 32; and

(d) two persons that are registered biokineticians elected to be members by the persons whose names appear in the register of biokineticians kept under section 32; and

(e) two persons that are registered clinical biochemists, elected to be members by the persons whose names appear in the register of clinical biochemists kept under section 32.

3. Subject to regulation 4, the period of service of members of the professional board shall be five years, reckoned from the date of the election referred to in paragraphs (b) to (e) of regulation 2: Provided that such members shall be eligible for re-election or re-designation, as the case may be.

4. (1) A member shall vacate office—

(a) if he becomes insolvent or assigns his estate for the benefit of or compounds with his creditors; or

(b) if he is absent from more than two consecutive ordinary meetings of the professional board without the professional board's leave; or

(c) if he has been disqualified under the Act from practising his profession; or

(d) if, as an elected member, he notifies the professional board, in writing, of his resignation; or

(e) if, as a designated member referred to in regulation 2 (a), he ceases to be eligible for designation or gives notice, in writing, to the council of his desire to resign from office and his resignation is accepted.

(2) Every vacancy occurring on the professional board shall be filled by designation or election, as the case may be, and every member so designated or elected shall hold office only for the unexpired portion of that period for which the member vacating such office was designated or elected.

POWERS OF THE PROFESSIONAL BOARD

5. The professional board may—

(a) make representations to or through the council for the making, amendment or withdrawal of any regulation or rule that applies to the professional board or to medical science or to medical physics or to biokinetics or to clinical biochemistry;

(b) submit representations through the council to the Minister as to the definition of the scope of the profession of medical scientist or medical physicist or biokinetician or clinical biochemist should the council recommend to the Minister, in terms of section 33 (1), that the scope of the profession of medical scientist or medical physicist or biokinetician or clinical biochemist be defined by specifying the acts which shall, for the purposes of the Act, be deemed to be acts pertaining to medical scientists or medical physicists or biokineticians or clinical biochemists.

(c) twee persone wat geregistreerde geneeskundige fisici is, as lede verkies deur die persone wie se name verskyn in die register van geneeskundige fisici wat ingevolge artikel 32 gehou word; en

(d) twee persone wat geregistreerde biokinetici is, as lede verkies deur die persone wie se name verskyn in die register van biokinetici wat ingevolge artikel 32 gehou word; en

(e) twee persone wat geregistreerde kliniese biochemici is, as lede verkies deur die persone wie se name verskyn in die register van kliniese biochemici wat ingevolge artikel 32 gehou word.

3. Behoudens die bepalings van regulasie 4 is die dienstermyn van lede van die beroepsraad vyf jaar, gereken vanaf die datum van die verkiesing bedoel in paragrawe (b) tot (e) van regulasie 2: Met dien verstande dat sodanige lede herkiesbaar is of weer aangewys kan word, na gelang van die geval.

4. (1) 'n Lid ontruim sy amp—

(a) as hy insolvent raak of van sy boedel afstand doen ten voordele van sy skuldeisers of met hulle 'n skikking aangaan; of

(b) as hy sonder die toestemming van die beroepsraad van meer as twee agtereenvolgende gewone vergaderings van die beroepsraad afwesig is; of

(c) as hy ingevolge die Wet onbevoeg geword het om sy beroep te beoefen; of

(d) as hy, as 'n verkose lid, sy bedanking skriftelik aan die beroepsraad meedeel; of

(e) as hy, as 'n regulasie 2 (a) bedoelde aangewese lid, ophou om aanwysbaar te wees of skriftelik aan die raad kennis gee van sy wens om te bedank en sy bedanking aangeneem word.

(2) Elke vakature wat in die beroepsraad ontstaan, word gevul deur aanwysing of verkiesing, na gelang van die geval, en elke aldus aangewese of verkose lid beklee sy amp slegs vir die onverstreke gedeelte van die tydperk waarvoor die lid wat sodanige amp ontruim het, aangewys of verkies was.

BEVOEGDHEDE VAN DIE BEROEPSRAAD

5. Die beroepsraad kan—

(a) vertoë tot of deur bemiddeling van die raad rig vir die uitvaardiging, wysiging of intrekking van 'n regulasie of reël wat op die beroepsraad of op die mediese wetenskap of op geneeskundige fisika of op biokinetika of op kliniese biochemie van toepassing is;

(b) deur bemiddelling van die raad vertoë tot die Minister rig met betrekking tot die omskrywing van die omvang van die beroep van mediese wetenskaplike of geneeskundige fisikus of biokinetikus of kliniese biochemikus indien die raad ingevolge artikel 33 (1) by die Minister sou aanbeveel dat die omvang van die beroep van mediese wetenskaplike of geneeskundige fisikus of biokinetikus of kliniese biochemikus omskryf word deur die handelinge te bepaal wat vir doeleindes van die Wet geag word handelinge te wees wat by mediese wetenskaplikes of geneeskundige fisici of biokinetici of kliniese biochemici tuishoort.

FUNCTIONS AND DUTIES OF THE PROFESSIONAL BOARD

6. It shall be the duty of the professional board to—

(a) promote high standards of professional education and professional conduct among medical scientists, medical physicists, biokineticians and clinical biochemists;

(b) report to the council on any matter affecting medical scientists or medical physicists or biokineticians or clinical biochemists referred to it by the council;

(c) advise the council on the removal under the provisions of section 19 or section 32 (2) of the name of any person from the register of medical scientists or medical physicists or biokineticians or clinical biochemists kept under section 32; and

(d) make recommendations to the council in regard to the recognition of institutions for the prescribed practical training of medical scientists or medical physicists or biokineticians or clinical biochemists and in regard to the recognition of qualifications of medical scientists or medical physicists or biokineticians or clinical biochemists whose names are placed on the register in terms of section 32.

7. These regulations published by Government Notice No. R. 1737 of 9 August 1985 are hereby repealed.

8. These regulations shall come into effect on 30 November 1990.

No. R. 2786 **30 November 1990**

THE SOUTH AFRICAN NURSING COUNCIL

REGULATIONS FOR THE COURSE FOR THE DIPLOMA FOR GENERAL NURSE INSTRUCTOR.—WITHDRAWAL

The Minister of National Health and of Health Services: House of Assembly has, on the recommendation of the South African Nursing Council, in terms of section 45 of the Nursing Act, 1978 (Act No. 50 of 1978), made the regulations contained in the Schedule hereto.

SCHEDULE

1. The regulations published under Government Notice No. R. 1514 of 21 July 1978, as amended by Government Notices Nos. R. 2204 of 31 October 1980, R. 1427 of 1 July 1983 and R. 2555 of 15 November 1985 (hereinafter referred to as "the Regulations") are hereby withdrawn with effect from 30 November 1990.

2. Notwithstanding the withdrawal of the Regulations, the provisions thereof shall continue to apply to a person who was registered as a student in terms of regulation 3 thereof before 30 November 1990: Provided that such student shall be allowed by the council to sit for the examination referred to in the Regulations only until 31 December 1991.

WERKSAAMHEDE EN PLIGTE VAN DIE BEROEPSRAAD

6. Dit is die plig van die beroepsraad om—

(a) 'n hoë peil van professionele onderrig en professionele gedrag by mediese wetenskaplikes, geneeskundige fisici, biokinetici en kliniese biochemici te bevorder;

(b) aan die raad verslag te doen oor enige aangeleentheid rakende mediese wetenskaplikes of geneeskundige fisici of biokinetici of kliniese biochemici wat deur die raad na hom verwys word;

(c) die raad te adviseer oor die skrapping, kragtens die bepalings van artikel 19 of artikel 32 (2), van die naam van 'n persoon uit die register van mediese wetenskaplikes of geneeskundige fisici of biokinetici of kliniese biochemici wat kragens artikel 32 gehou word; en

(d) aanbevelings by die raad te doen omtrent die erkenning van inrigtings vir die voorgeskrewe praktiese opleiding van mediese wetenskaplikes of geneeskundige fisici of biokinetici of kliniese biochemici en omtrent die erkenning van kwalifikasies van mediese wetenskaplikes of geneeskundige fisici of biokinetici of kliniese biochemici wie se name kragtens artikel 32 op die register geplaas word.

7. Die regulasies afgekondig by Goewermentskennisgewing No. R. 1737 van 9 Augustus 1985 word hierby herroep.

8. Hierdie regulasies tree op 30 November 1990 in werking.

No. R. 2786 **30 November 1990**

DIE SUID-AFRIKAANSE RAAD OP VERPLEGING

REGULASIES VIR DIE KURSUS VIR DIE DIPLOMA VIR ALGEMENE VERPLEEGINSTRUKTEUR.—HERROEPING

Die Minister van Nasionale Gesondheid en van Gesondheidsdiente: Volksraad het, op aanbeveling van die Suid-Afrikaanse Raad op Verpleging, kragtens artikel 45 van die Wet op Verpleging, 1978 (Wet No. 50 van 1978), die regulasies in die Bylae hiervan vervat, uitgevaardig.

BYLAE

1. Die regulasies afgekondig by Goewermentskennisgewing No. R. 1514 van 21 Julie 1978, soos gewysig by Goewermentskennisgewings Nos. R. 2240 van 31 Oktober 1980, R. 1427 van 1 Julie 1983 en R. 2555 van 15 November 1985 (hierna "die Regulasies" genoem), word hierby met ingang van 30 November 1990 herroep.

2. Ondanks die herroeping van die Regulasies bly die bepalings daarvan van toepassing op 'n persoon wat hom voor 30 November 1990 uit hoofde van regulasie 3 daarvan as 'n student laat registreer het: Met dien verstande dat sodanige student slegs tot 31 Desember 1991 deur die raad toegelaat sal word om die eksamen bedoel in die Regulasies af te lê.

Health care should be for all, says human rights activist

South 6/12 - 12/12/90

By CHIARA CARTER

PRIMARY health care should be made available to a much greater range of people in South Africa.

This view was expressed by Ms Mary Burton, the newly-appointed commissioner for Human Rights in the Western Cape, at a graduation ceremony for the Medical and Music schools at the UCT campus this week.

Burton said it gave her "special satisfaction" to be part of the ceremony at which UCT's first black women doctors graduated and at which the first Master of Science Nursing degree was conferred.

Disadvantaged

"I hope the time will come when there will be no reason for special comment on the achievements of people who are female or black," Burton said.

"For the present, however, their success offers encouragement to the many others, also disadvantaged by gender or racial classification, who will follow them."

Burton said the provision of health care was becoming prohibitively expensive and this was aggravated by the trend towards privatisation.

Fund may provide loan relief for needy students

South 13/12 - 17/12/90

CASH-STRAPPED black students may receive relief from the high cost of tertiary education if plans to implement a national loan scheme are successful next year.

The Independent Development Trust (IDT), administered by Mr Jan Steyn to allocate R2bn set aside for urban development, has approved several innovative projects in education, health and housing that will cost more than R160m.

The IDT is examining the possibility of a national loan scheme for funding tertiary education, specially for the most disadvantaged students who are unable to find support for their studies.

Leading educators from all over South Africa assisted in determining the IDT's priorities during September and October this year.

Specific areas in which the trust could perform a catalytic function and develop role models for broader replications were then canvassed and investigated in the field, throughout South Africa.

They want to give greater access through investment to educational opportunities for disadvantaged students.

Technikons

The IDT has allocated R495 000 to the Medical University of South Africa (Medunsa) for an academic development programme in natural sciences and R500 000 to UWC to support their academic development programme.

Technikons admitting black students, like the Mangosuthu Technikon and Wits Technikon, have received R2m.

The IDT has allocated R600 000 to the Education Foundation for the establishment of a national clearing house for educational data in the country.

JAN STEYN
Fund administrator

ANC provides homes for backyard

South 6/12 - 12/12/90

THE Mossel Bay branch of the African National Congress and the local civic organisation have decided to provide shelter for the thousands of homeless in the South Cape town.

Since November 28, more than 300 shacks have been erected in the Kwanonqaba township under the supervision of the two organisations.

"We drew up a list of all the homeless people, which totalled 3 800," said Mossel Bay Advice Office worker Mr Johannes Yantolo.

"Some of the people were sleeping in the bushes or in the backyards of people's homes in the township."

The organisations met with the Cape Provincial Administration on November 26 to tell them of their plans.

They were told the land belonged to Eskom and that permission could not be granted for the construction of dwellings.

A second meeting will take place on January 30 next year.

"The police have visited the shack area to ask who was responsible for building them," said Yantolo.

"The residents told them they had decided they could no longer wait for the CPA to implement its promise to provide land.

"Since then, police have been tried a few times to find out who is responsible, but no

VAT will be test of farmers' bookwork

BIDay 6/12/90

FARMERS would have to get their paperwork and accounting systems in order or lose out on credit refunds when the value added tax (VAT) system was introduced next year, accountants said yesterday.

They would not be able to leave their paperwork until year-end as was the case with GST. The VAT system was invoice-driven and invoices had to be supplied whenever a taxable service was received or supplied, the accountants said.

While efficient farmers had nothing to fear from the introduction of VAT — provided they already had good accounting systems — those without proper accounts would have difficulty in reclaiming the tax component included in their bills for purchased inputs.

When all tax paid on purchases or services (input tax) was deducted from the total tax farmers charged their customers (output tax), farmers could claim credit only if input was greater than output.

To a certain extent VAT would provide a built-in checking mechanism and although tax collected would have to be paid over to the tax authorities, VAT paid and shown on invoices could be claimed as a tax credit paid on goods and services obtained for farming purposes (inputs).

"The ideal VAT system should have as few exceptions and zero-ratings as possible to ensure that it will be a broad-based consumption tax," said Mark Badenhorst of Price Waterhouse.

MARIETTE DU PLESSIS

He added that all primary producers such as farmers, fishermen and timber growers would have to be included to safeguard the integrity of the system.

There were large numbers of farmers on medium-sized farms who would be caught in the middle between the large primary producers and small producers.

They would be faced with the problem of ensuring that their accounting systems and records complied with requirements such as VAT registration, which was necessary to claim input tax credit, and correct invoicing, giving the registration number and amount of tax charged, Badenhorst said.

Refunds

An insignificant percentage of small farmers falling below the threshold turnover limit of R50 000 would be exempted and, therefore, not liable to comply with the VAT requirements, while large producers already had accounting systems and records to ensure adequate compliance.

Because farming was seasonal, farmers would tend to claim refunds at the beginning of the agricultural year, when purchasing inputs, before making heavy payments to the Receiver after harvest, economists said. This made government revenue more seasonal.

Appeal over health budget

85

PRETORIA — The Medical Association of SA yesterday appealed to President F W de Klerk to give urgent priority to the health care budget for next year.

In a letter to De Klerk, Masa said it was seriously concerned about the deterioration of health services in the public sector.

This was caused by the loss of public sector health personnel to the private sector and to jobs in other countries because of inadequate pay, stressful work, outdated equipment and lack of career incentives at state hospitals. BIDay 6/12/90

Wits University's Specialists Association, using information from medical personnel at medical schools, estimated 76% of the doctors planned to move to the private sector; 41% were considering emigrating; and 9% planned a career change.

It was feared if the trend of losing state doctors continued, public sector health care services would be unable to provide care for a growing population.

Masa secretary-general Hendrik Hanekom stressed the vast majority of South Africans were totally dependent on state health care services. A preliminary report by management consultants commissioned by Masa warned that losses of senior practitioners and administrators to the private health care sector were a major threat to the public health sector.

GERALD REILLY

Hanekom stressed that in the past 10 years there had been increasing concern over the deteriorating standards of academic medicine.

The standard of health care was determined by academic medicine standards and Masa had warned for years that urgent steps were needed to head off the crisis now developing.

Masa, Hanekom said, was waiting for feedback from a leadership conference on academic medicine held earlier this year but in the meantime it had started its own investigations into the funding aspect.

Masa plea to De Klerk

Sowetan 7/12/90

Own Correspondent

THE Medical Association of South Africa has appealed directly to President FW de Klerk to give priority to the health care budget next year.

In a statement released in Pretoria, Masa says that it has "expressed its serious concern over the deterioration of health services in the public sector."

The deterioration included a loss of personnel to the private sector and to posts overseas due "to the inadequate remuneration, stressful working conditions, outdated equipment and lack of career incentives at State hospitals".

Masa says 76 percent of doctors who are members of the Full-time Specialists Association at the University of the Witwatersrand, planned to move to the private sector while 41 percent were considering emigrating and nine percent planned a career change.

Dr Hendrik Hanekom, the association's secretary-general, pointed out to the State President that the vast majority of South Africans were dependent on State health care services and "a further decline in the standard of medicine practised at State hospitals would have a serious negative impact on the health of those patients".

DAY, Friday, December 7 1990

Public health faces crisis over specialists' grievances

B Day 7/12/90.

B Day 7/12/90

AT LEAST 80% of full-time medical specialists intend leaving the public health service within two years if conditions do not improve, says a survey by specialist associations.

MATTHEW CURTIN

A spokesman for the Association of Specialists of the University of the Witwatersrand (ASUW) said yesterday the survey, based on the anonymous responses collected from 25% of SA's full-time specialists to two questionnaires, found nearly one in 10 specialists were considering leaving the medical profession.

When doctors with 15 years training were prepared to abandon their profession because of poor working conditions, it showed the critical condition in which academic medicine in SA found itself, he said.

By the end of 1990 Johannesburg Hospital would be without any neurosurgical specialists, sistopathologists, and half the necessary complement of anaesthetists, while there were reports half of Baragwanath's senior surgeons were about to resign.

The spokesman said of the specialists interviewed, 96% felt "very strongly" that salaries were inadequate and 80% said provincial administrations did not sufficiently appreciate academic medicine. There was also inadequate time for medical research.

But 93% of the doctors said if they were allowed to generate private income while still fulfilling stringent medical audits for the public service they provided, it would recompense them for their poor salaries.

Reconstruction

The Medical Association of SA (Masa) presented the survey's finding to National Health Minister Rina Venter at a meeting in Pretoria on Wednesday.

Venter said yesterday the government was "fully aware" of the problems raised by the survey.

It was for these reasons that government had embarked on a health services "reconstruction programme", but she warned "adjustments cannot be made immediately".

In the statement Venter said some steps had been taken already. There had been "much progress" in drafting a "management model for academic hospitals" and the Ministry was reviewing the salaries and career opportunities of all hospital staff.

The SAUW spokesman shared the minister's concern and hoped action would be swift to avert a deepening of the crisis.

Sapa reports Medical Association of SA secretary-general Hendrik Hanekom said yesterday the association had made an urgent appeal to President F W de Klerk to give priority to the health care budget for 1991.

He said the fact personnel were being lost to the private sector and to foreign posts was due to inadequate remuneration, stressful working conditions, outdated equipment and lack of career incentives at hospitals.

There was serious cause for concern over the "the deterioration of health services in the public sector".

A further decline in the standard of medicine practised at state hospitals would have a serious negative impact on the health care of the vast majority of people who were totally dependent on state health care services.

Cam- Trust 10/12/90 85

Cap

R160m for housing, health, schools

Own Correspondent

JOHANNESBURG. — The Independent Development Trust (IDT) has approved funding amounting to R160 million for a range of housing, education and health projects, IDT chairman Mr Jan Steyn said yesterday.

Mr Steyn said in a statement that approval for the projects had been secured particularly quickly without compromising the IDT's commitment to consulting the community on the issues involved.

The IDT has allocated R11 million in support of a credit company to provide small loans for the supply and upgrading of informal housing.

IDT finance director Mr Jannie Kitshoff said yesterday that the scheme could be the first in Africa which could facilitate the mobilisation of small loans to lower-income families for housing.

IDT housing director Mr Ben van der Ross said the focus of the project would be on site-and-service schemes and starter housing.

Mr Steyn said the IDT was negotiating a R70-million loan with the Urban Foundation to ease its ability to provide shelter for the very poor, but stressed that the Foundation itself would be required to raise R100 million from financial institutions and that funding was conditional on "maximum community participation ... in all aspects of the projects".

He said much of the funding had been allocated to educational projects and the IDT expected to invest "tens of millions of rands" in the pre-school/educare area alone.

The IDT had allocated R10 million to technical education and was investigating the possibility of a national loan scheme for funding tertiary education for disavantaged students in particular.

The trust had already contributed R4 million of a R39-million package for the Vusisizwe Trust's programme to rebuild schools and classrooms destroyed recently in the Eastern Cape.

Mr Steyn said almost R6 million had been earmarked by the "fledgling" IDT health division.

Prof Mamphela Ramphela, recently appointed director of the IDT, said: "The whole issue of health care in SA is a complex and emotive one. We will endeavour to assist the process of making the provision of health care — for all the people of this country — equitable, accessible, affordable and free of discrimination of any kind."

Mr Kitshoff said the IDT began operations in August after R2 000 million had been transferred to it in mid-July "to meet the development needs of the poorest of the poor in SA".

Cancer Association forced to cut budget

By Carina le Grange

Speculation that the Southern Transvaal Branch of the National Cancer Association (NCA) is to close down have proved to be false.

However, the NCA is planning to rationalise its services and some staff members are expected to be retrenched, according to president Professor Douglas Anderson.

These moves are a result of rising costs and an increase in demand from patients while public donations have dropped concurrent with the economic climate, the NCA said yesterday.

On reports that members of staff at the Southern Transvaal branch received notice of their retrenchment, Professor Anderson said the NCA was looking at retrenchments as only one of the measures of meeting the budget.

He said these letters did not "finalise their retrenchments", but could not say how many people would be affected countrywide. He denied the NCA was going bankrupt and would close down, but added there would be no expansion of services as in past years.

The NCA offers services free to cancer patients and their families, ranging from counselling to prostheses, from pain control to support during bereavement.

It is totally reliant on public donations, with less than one percent of its operating costs subsidised by the State.

Health budget due to rise by 0,04%

GOVERNMENT is expected to increase its health budget just 0,04% next year when the restructuring of health services will gain momentum.

National Health Minister Dr Rina Venter said yesterday the country's 13 academic hospitals would be rationalised as soon as possible in 1991.

She said Administration and Economic Co-ordination Minister Wim de Villiers would continue to probe hospital administration and was due to make his report next year on the high cost of medicine.

Although the 1991/92 health budget had not been finalised, a provisional R7,3bn had been allocated, a department spokesman said. This year's R7bn budget represented an 8% increase on that of 1989.

Venter said she had sent to the Commission of Administration a motivation for further salary increases for public sector doctors and nurses next year.

The resignation of top surgeons and strikes by non-medical workers revealed the extent of the crisis in state hospitals.

A recent survey by the Association of Specialists of Wits University showed about 80% of full-time medical specialists would leave the public health sector in the next two years unless pay and working conditions improved.

TANIA LEVY

Wits University doctors have proposed that teaching hospitals be rationalised into regional complexes and administered by boards of control representing universities, the state and the wider community. The boards would control hospitals' state funding which would be supplemented by private patient fees.

Almost half the annual health budget is allocated to academic hospitals.

Venter said a new model for academic hospitals was being developed in consultation with relevant parties.

Proposals for the revision of the 1967 Medical Schemes Act would be elicited next year but a draft Bill would only be put before Parliament in 1992.

Venter said the moratorium on the building of new hospitals would remain in place next year, although 50 primary health care clinics would come on stream.

Bed occupancy had not changed much after the desegregation of hospitals in April. The number of available beds was the same because of limited funds, although beds were avaialable to all races.

Government's newly formed Inter-departmental AIDS committee would meet on January 23 in Cape Town.

No proof of third force, says Vlok

LINDEN BIRNS

SOME of the elements involved in the recent township violence had an unusual degree of training and skills, but government still had no concrete proof that an alleged "third force" existed, Law and Order Minister Adriaan Vlok said.

In an interview with the Bureau for Information's RSA Policy Review Vlok was asked about the existence of an "orchestrated, professional terrorist offensive" by a so-called third force.

The SA Police, Vlok said, had no concrete evidence to substantiate these claims.

"It is, however, significant that some of the violent actions indicated a degree of training and skill which common criminals lack," he said.

In September ANC deputy president Nelson Mandela told journalists that President F W de Klerk had conceded that a third force existed.

However, De Klerk later denied he had said this.

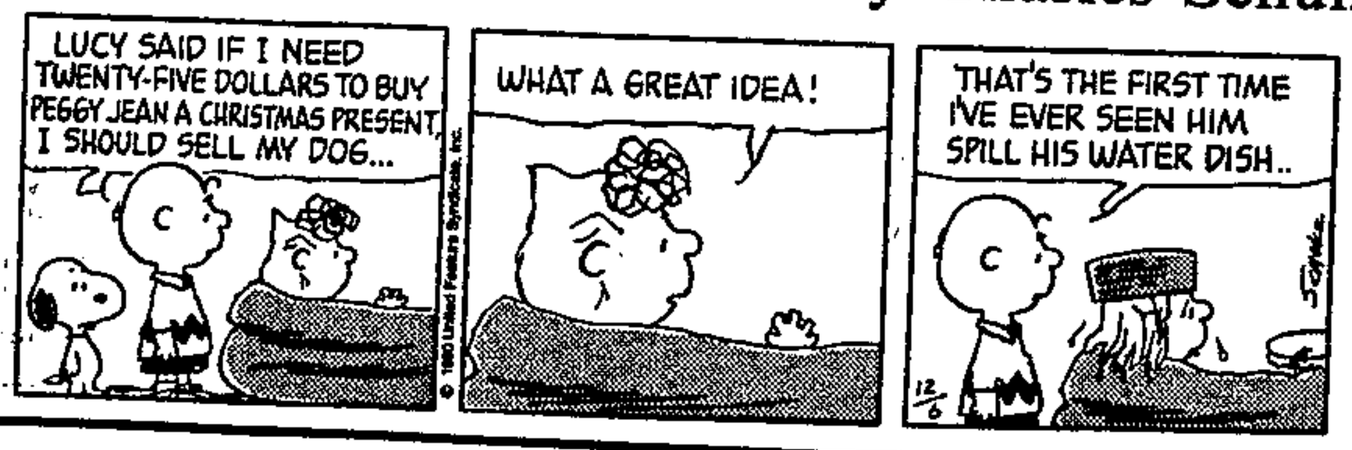
Vlok and his spokesman were unavailable for further comment last night.

In the interview Vlok said the wave of black-on-black violence "essentially has political objectives".

"Therefore a political solution is necessary to finally end it.

"Security action is, however, necessary to clamp down on rioters."

PEANUTS By Charles Schulz



Health care apartheid is still intact — researcher

TANIA LEVY

APARTHEID in health care remained largely intact despite government's statements that it had been abolished, the Wits Centre for the Study of Health Policy found.

In practice little had changed since National Health Minister Rina Venter's announcement that hospitals were open to all races and beds were to be used according to need, said research officer Johnathan Broomberg.

Venter's statements had left too many loopholes to ensure real integration, he said.

Many public hospitals in the country were not exclusively black or white but had separate wards, different entrances, segregated outpatient and casualty wards and sometimes even separate X-ray and theatre facilities for black and white patients.

Citizen 20/12/90

Segregated

The new policy did not require that segregation within hospitals be abolished, he said. And Venter's announcement did not extend to local authority services.

Broomberg said most previously segregated hospitals continued to serve only one population group because they were the most conveniently situated for the local communities.

He said the administration of health services by racially separate own affairs departments and 10 homeland health departments was "administratively irrational and economically inefficient". He said it perpetuated racial inequality.

For example R23,04 per person was spent in Lebowa compared with R149,51 per person in the Transvaal.

Dismantling hospital apartheid required a clear unambiguous public policy from Venter.

HEALTH & DISEASE - GENERAL

1991

Junior doctors air grievances

PRETORIA. — A delegation of the Junior Doctors' Association of South Africa (Judasa) met the Director-General of National Health and Population Development, Dr Coen Slabber, here to discuss grievances.

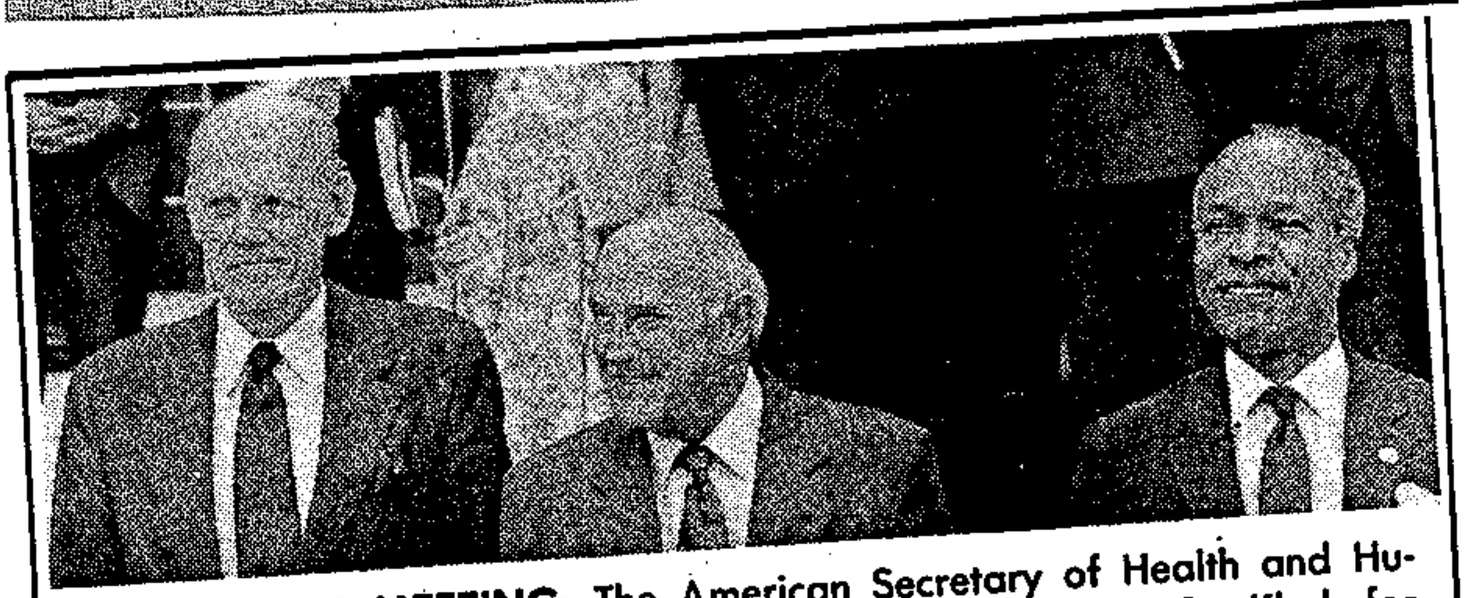
A statement by the Medical Association of South Africa (Masa) issued after the meeting said it was agreed that the interests of patients and the health care industry had priority and that a commitment to a non-racial health care structure for South Africa was also a common goal.

Judasa appealed for better pay and working conditions for its members. — Sapa.

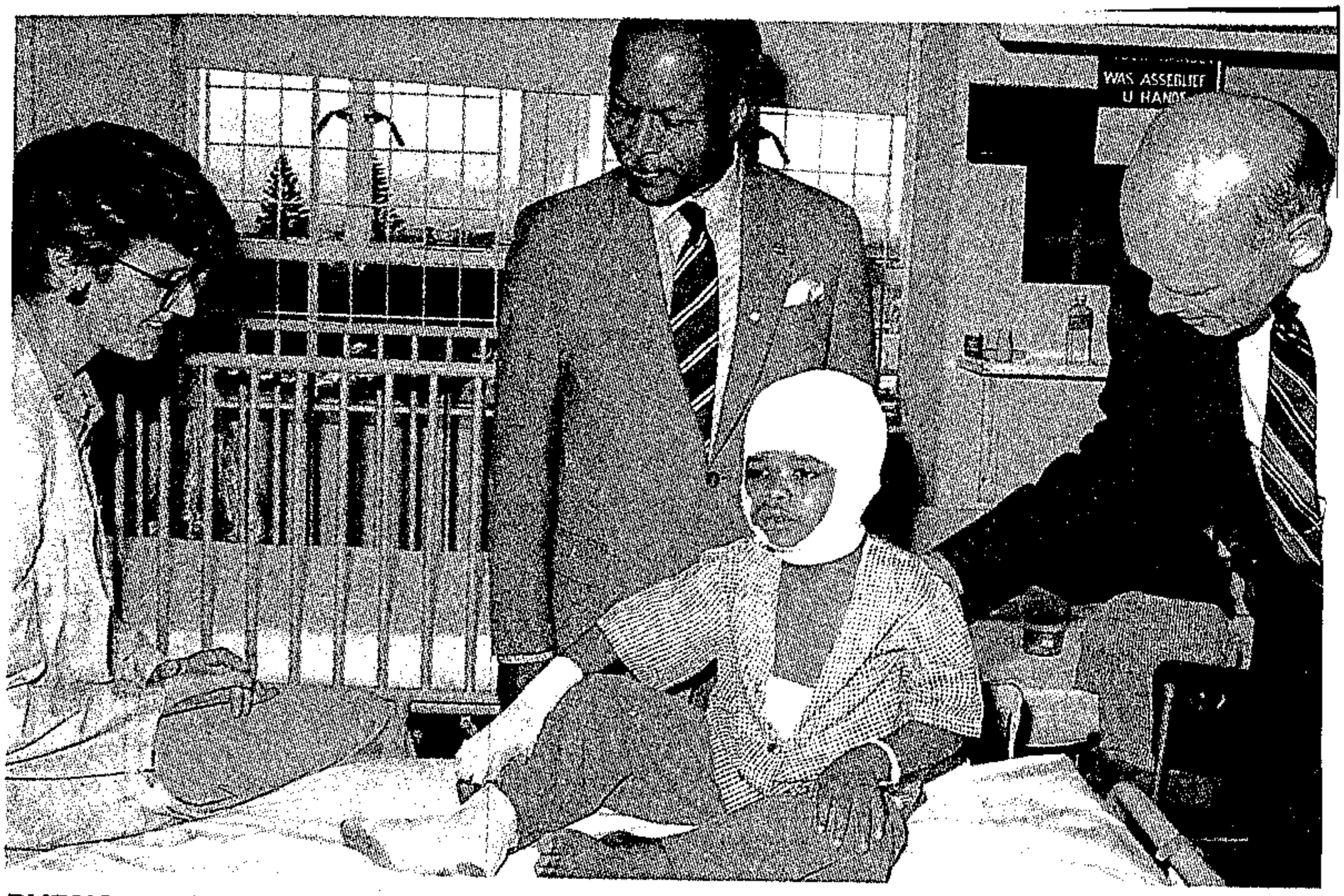
Star 17/1/91 (85)

52 bursaries

The Medical Research Council has granted 52 postgraduate bursaries, valued at R412 000, for studies at SA universities this year. Ten bursaries were granted to honours students, 21 to master's students and 21 to students studying towards a doctoral degree. The bursaries are awarded for studies in the medical fields on the basis of academic achievement and the relevance of the research to SA.



PRESIDENTIAL MEETING: The American Secretary of Health and Human Services, Dr Louis Sullivan, right, has met President De Klerk for talks. Dr Sullivan, who conveyed greetings to Mr De Klerk from President George Bush, was accompanied by the administrator of the Agency for International Development, Dr Ronald Roskens. Yesterday's hour-long talks focused on health and child welfare. The Americans, on an eight-nation tour of Africa, were sent by Mr Bush to see how the United States could promote child survival across the continent and the world. The mission focuses on efforts to improve child survival and on the impact of Aids, particularly as it affects mothers and children. Dr Sullivan and Dr Roskens are to visit a day care centre in Khayelitsha and the Red Cross Children's Hospital today. Picture: DOUG PITHEY, The Argus.



BURNS VICTIM . . . Dr Linda Jones (left) of the Red Cross Children's Hospital presents burn victim Bulelani Bokeni, 5, to visiting US Health Secretary Dr Louis Sullivan (middle) and Development administrator Dr Ronald Roskens yesterday. Picture: STEWART COLMAN

Cape Times 16/11/91 85

SA lags behind Africa on Aids

By CHRIS BATEMAN

SOUTH Africa compared poorly with other African countries such as the Ivory Coast, Malawi and Uganda when it came to public Aids awareness, the United States Secretary of Health, Dr Louis Sullivan, said yesterday.

Dr Sullivan said he had been "very impressed" by the level of Aids awareness in other African countries, fostered by extensive education from pre-primary level upwards.

However; "we have not seen that here in SA", he said.

Dr Sullivan is on a 17-day tour of Africa to assess child-welfare and Aids programmes. He is being accompanied by Dr Ronald Roskens, the administrator of the US Agency for International Development, and 25 staffers.

The mission, undertaken at the request of US President George Bush, is to determine "what America and the world can do to advance child survival across Africa".

Dr Sullivan who first visited South Africa in November 1987, said that apartheid still existed "in fact while perhaps not in principle".

This was illustrated by the national infant mortality statistics — 58 per 1 000 blacks versus six per 1 000 whites — given to him by National Health and Population Development Minister Dr Rina Venter.

Yesterday he and his entourage visited the Khayelitsha Day Hospital, which although designed to service 65 000 people was dealing with the needs of 500 000.

He was told that the infant mortality in Khayelitsha was 40 per 1 000, whereas the equivalent white statistic in Cape Town was 10 in every 1 000.

"There are some serious health problems here that the entire nation needs to focus on," Dr Sullivan said.

The United States could play a supplementary role, possibly in the form of technical assistance.

Dr Sullivan later visited the Red Cross Children's Hospital, which he was told was threatened by state budget cuts and overwhelmed by "inappropriate" referrals.

Major study on childhood injury in SA

ROAD accidents are a major cause of injury-related deaths of South African children up to the age of 14, a study by the Medical Research Council has found.

The study, the first in-depth inquiry into childhood injury in South Africa, found that between 1968 and 1985 over 30% of all injury-related deaths of children were caused by traffic accidents.

The Medical Research Council, with the Child Accident Prevention Foundation at the Red Cross Children's Hospital and the Institute of Child Health at UCT, studied all registered deaths of children under 15 in South Africa from 1968 to 1985.

They found that between 1968 and 1985 road and burn death rates decreased while assault and drowning rates increased. The decrease in road deaths could be attributed to increased public awareness created by campaigns, they said.

Accidental choking and suffocation resulted in the majority of accident-related deaths of children under 12 months.

Drowning accounted for 19% of injury deaths and burns for 11%. In 14% of cases it could not be determined if the injury was accidental or "purposefully inflicted".

"Road deaths had the greatest impact on white children, while burns and assault played a greater role in the black, coloured and Asian populations," the report said.

Eighty-four children aged between 10 and 14 committed suicide between 1981 and 1985 while 225 children under 15 were killed by firearms or explosives in this same period.

MOH calls for redistribution of health cash

ARGUS 30/1/91

85

By VIVIEN HORLER
Medical Reporter

SOUTH Africa could provide comprehensive primary health-care for everyone if it realligned the resources it already has, says Dr Nick Padayachee, Johannesburg's deputy medical officer of health.

"We have enough money to provide basic health-care for everyone, but that money is not being spent where it should be. The major problem is with the allocation of resources," he said.

Dr Padayachee was speaking at a conference on "Health Informatics for Southern Africa" at the University of Cape Town yesterday. "Informatics" is the discipline of the gathering, retrieval and use of information and databases.

Alexandra

An earlier speaker, Dr Hans Steyn, deputy director-general of the Department of Health, told the conference that 6,4 percent of the gross national product (GNP), or R264 a head a year, went to health services.

Dr Padayachee said that based on the figures of a clinic in Alexandra township near Johannesburg, comprehensive primary health care could be provided for the entire country for R50 a head a year.

The problem was that too much money was spent on expensive, high-tech health care, and not enough on basics, he said.

About 3,25 hospital beds were needed for every thousand people, one of which would be at a small, cottage-type hospital, two at regional hospitals such as the Kimberley hospital, and 0,25 at the major tertiary hospitals such as Groote Schuur and Tygerberg.

Dr Padayachee said there were 4,8 beds for every thousand people. But based on figures for greater Johannesburg, just over 4 000 beds were in community and regional hospitals "where we need 6 500, while 4 800 are in tertiary hospitals, where we need just 1 800".

"Based on a population of 30-million, 1 140 doctors and 11 010 nurses would be needed to attend to primary health care needs.

There are 20 000 doctors and 100 000 nurses, but most provide hi-tech services, Dr Padayachee said.

Concern over disparity in SA's health statistics

By VIVIEN HORLER
Medical Reporter

SOUTH African health statistics compare favourably with the rest of Africa and Latin America, yet the internal statistics reflect problems, says the deputy director-general of health, Dr Hans Steyn.

Speaking at the fourth Health Informatics for Southern Africa conference at the University of Cape Town yesterday, Dr Steyn said life expectancy at birth in South Africa was 63 years, compared with 51 years in the rest of the continent and 66 years in Latin America.

The conference was told that life expectancy at birth for whites here is 71, while it is 62 for blacks.

The infant mortality rate here is 50 for every 1 000 live births, compared with 113 in Africa, 105 in Asia and 55 in Latin America.

Yet the infant mortality rate among South African whites is 13 for every 1 000 live births, and 57 for blacks. The birth rate in 1985 for every 1 000 people was 16 for whites and 39 for blacks.

● Informatics is described as the gathering, retrieval and use of information and databases.

Public servants in 'breakthrough' talks

A RECENT meeting between public service health organisations, trade unions and the state's Commission for Administration (CFA) has raised hopes that the Public Services Act will be reformed.

The Act, which has prevented public servants the right to collective bargaining, came under focus after numerous strikes by public servants last year.

The week-long meeting between the CFA and 11 organisations, including the white Public Servants Association (PSA), the "coloured" Public Servants League (PSL), the South African Nursing Association (Sana), the National Education, Health and Allied Workers Union (Nehawu) and the Health Workers Union (HWU), took place in Pretoria last week.

It was the second meeting between the parties.

The CFA, with 600 000 public servants under it, agreed in principle that the law would have to change.

According to HWU general secretary, Mr Dale Forbes, the parties initially could not reach agreement on the question of arbitration if a deadlock was reached in proposed negotiations.

However, a compromise was reached with the suggestion that "experts" be brought in should deadlock occur.

Forbes described the meeting as a "major breakthrough".

"There has never been a situation before where the government has asked staff associations to negotiate legislation." (85 [illegible])

A working committee was formed from representatives of the 11 organisations and the CFA.

The committee will meet on February 18. Sowth 7h-13/2/91

The CFA's chief director of labour relations, Mr Danie Du Toit, said he was confident the process would go well.

"We have more common ground than differences," Du Toit said from Pretoria this week.

Add oomph to geriatric medicine

Life expectancy in most westernised countries is increasing for a variety of reasons, including technological advances in medicine. South Africa unlike most Western countries, is not increasing its medical support for older people.

In South Africa, geriatric medicine is beginning to have a moribund look, says Professor Peter de Vos Meiring, who holds the country's only university chair in geriatric medicine, at UCT.

Life expectancy in most westernised countries is increasing for a variety of reasons including technological advances in medicine. But South Africa, unlike most Western countries, is not increasing its medical support for older people, says Professor Meiring.

In spite of South Africa's political standing, our medical profession has always maintained a high profile, with some disciplines excelling to equal the best anywhere, he says, in the latest issue of The Journal of Age-Related Disorders.

In spite of the widely acknowledged importance of the shift in population over recent decades, geriatrics is an area of medicine that could easily be labelled not only poor, but neglected, he says.

A dramatic shift of interest in age-related disorders shows that the elderly's importance is recognised and acknowledged in most Western countries, he says. Most medical schools actively support a chair of geriatrics with consultative, registrar and houseman posts to staff specific hospital wards and growing demands for beds.

There are also numerous auxiliary and support services to complement these geriatric units to improve patients' quality of life, and keep them independent and in the community for as long as possible.

This obviously has enormous cost benefits to any health care programme or policy, Professor Meiring says.

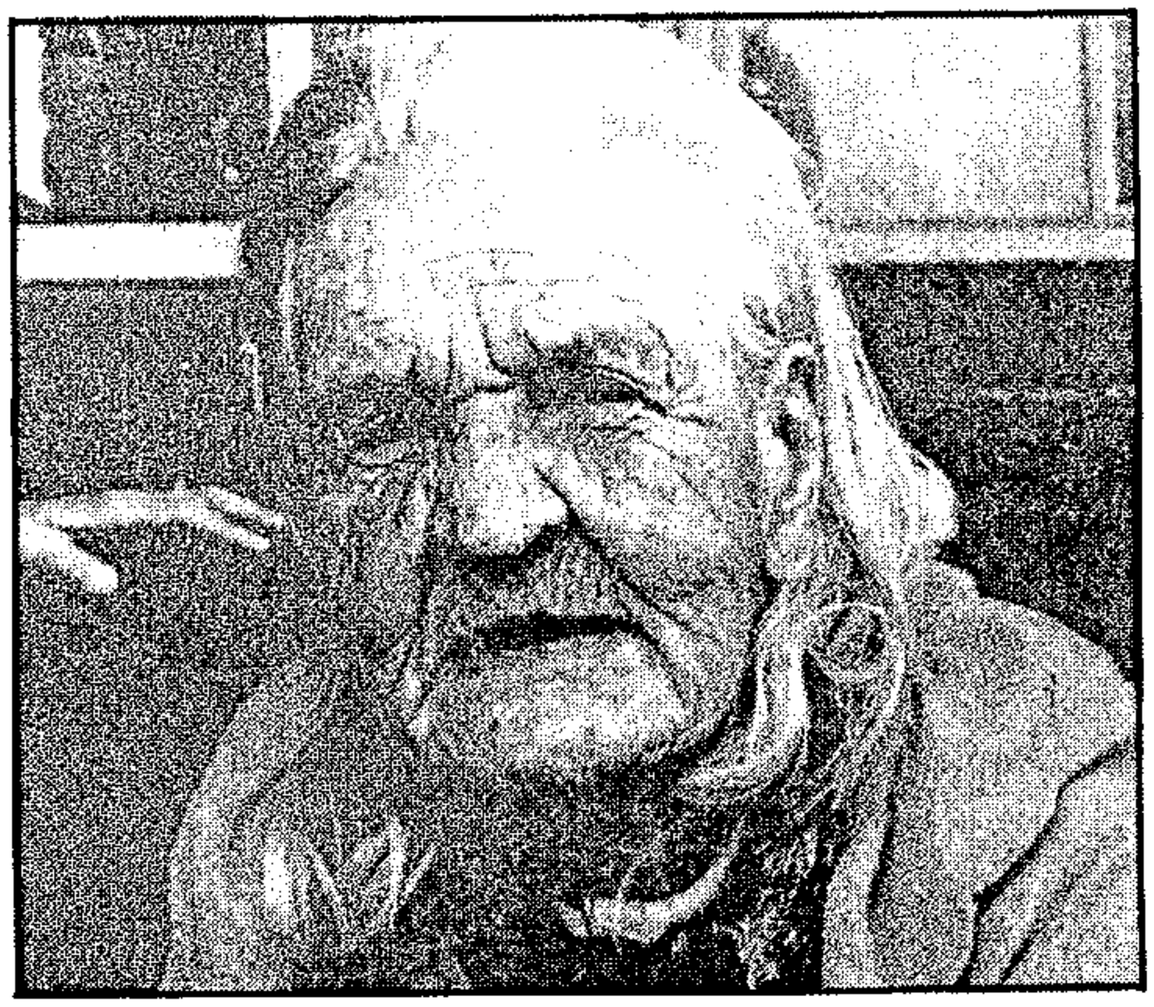
"In South Africa there is a dearth of information on the over-50 patient population," he says.

This is evident in the lack of innovative and clinical research in this area. And what speaks volumes is the fact that there is only one active chair of geriatrics among the country's seven medical schools, he says, especially as the demographic shift in population is a widely accepted fact.

The health implications are enormous for the new South Africa as this shift continues. Unless adequate provision is made now for teaching, research and clinical study into age-related disorders, the outlook is bleak, he says.

"Perhaps there is a typical South African perception prevailing in some quarters that if the problem is ignored it will just go away."

MARIKA SBOROS



Neglected . . . South Africa falls to address the medical problems of its over-50s, says an expert.

*The MINISTER: If there were not a CP town, this would not have been mentioned here. Our department negotiated . . . The costs of the town . . .

*The CHAIRMAN OF THE HOUSE: Order! We cannot allow further interjections when the hon the Minister is replying. He is replying—he is summing up and saying what has been done or what has to be done.

*The MINISTER: We are not going to buy ourselves a pig in a poke. The entire sewerage system of this town has to be replaced. If hon members have read yesterday's edition of *Die Burger*, they will know that there is already a Black woman living in Orania. He is not aware of the fact that there are irrigation lands in Orania. The farmers are moving there in order to farm there, because a dam has been built. He does not even know that. [Interjections.] That is why the town was built. The people were employed to build a dam. The Whites who are moving there are going to farm there. [Interjections.] Hon members know just as well as I do that there is not a single farm that does not make use of Coloured or Black labourers. Those Coloured people are going to live in that town because job opportunities have been created for them by the Whites who have moved there. [Interjections.] All of a sudden those hon members are believing in the CP's story that this town is going to become totally White forever. [Interjections.] The point is that those people are going to find work there because job opportunities have been created there. The Department of Water Affairs is already providing for its workers by seeking alternative accommodation for them.

Negotiations took place for a year. When Mr Pretorius bought the land, he wanted to resell it to us at a profit. We shall make the facts available because we do not have time to mention them all today.

These are prefabricated houses. The sewerage and water systems will have to be examined and attention will also have to be paid to operating costs. Would the poor people who are living there be able to afford the services if the town were to be upgraded to a town for Coloured people only? A thorough investigation has been conducted and we cannot simply give way if hon members wish to play political games just because the CP has purchased the town. Just read yesterday's edition of *Die Burger*, because there is a Black woman working there as a domestic servant.

*The LEADER OF THE OFFICIAL OPPOSITION: You have never come forward and explained what you are saying now!

*The MINISTER: Do hon members believe that all the Whites who are going to move there will do all the farm work themselves? [Time expired.]

Debate concluded.

HOUSE OF DELEGATES

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

General Affairs:

Spokesperson: National Health matters

Mr M RAJAB asked the Minister of National Health:

(1) Whether her Department has issued a document entitled "Department of National Health and Population Development: Guidelines for Media Liaison on Health Services"; if so,

(2) whether, in effect, these guidelines amount to the Minister of National Health being appointed as the sole spokesperson for national health issues; if so, for what reasons was this document issued?

D10E.INT

The MINISTER OF NATIONAL HEALTH: Mr Chairman, I welcome the opportunity to give the correct information on this document. The answer to the question as to whether the Department of National Health and Population Development issued a document entitled *Department of National Health and Population Development: Guidelines for Media Liaison on Health Services* is yes.

The question as to why this document was issued relates directly to a Cabinet decision taken on 28 March 1990, whereby the Minister of National Health and of Health Services in the House of Assembly was assigned the task of managing a national communication plan. This plan makes provision for the co-ordination of statements regarding aspects of national policy by the central Government. Furthermore, all statements by health administrations regarding national health policy matters should fall within the framework of such a communication plan.

The Minister of National Health was not appointed by this document as the sole spokesperson for national health. This document merely clarifies who is responsible for what. There should, as a matter of course, be only one mouthpiece regarding general national health matters, and that is the Minister of National Health and of Health Services in the House of Assembly. Should a specific political incumbent or institution, such as an own affairs administration, touch upon matters that also have a bearing on general national health matters, consultation at national level will be required at the outset. In all other cases the co-ordination of media liaison concerning issues that are not related to national policy takes place within own ranks at executive level.

An exception to this rule is when health services are run on an agency basis on behalf of the provincial administration, for instance in the case of family planning, when consultation is vital before statements are issued. A further example is where a province renders a service on behalf of an own affairs administration.

Executive functions rest mainly with the provinces and they themselves offer comments if the issue is not of national interest as far as policy is concerned.

It should be clear that the intention was not to gag anybody. In fact, greater co-ordination regarding statements pertaining to policy aspects at national level will prevent confusion among the public, the media and other interested parties.

Mr M RAJAB: Mr Chairman, I was very pleased to hear the hon the Minister say that this document was not meant to gag the media. However, I have looked at this document and—I say this with respect to the hon the Minister—if one reads this document one gains the impression, from the authoritarian tone used to formulate the guidelines, that this document is out of step with this Government's policy of moving towards a democracy which also includes freer communication through the media. I say, also with great respect to the hon the Minister, that these guidelines are a retrogressive step.

It is our considered view that these sanitised guidelines create an unhealthy mood which effectively gags the media. It also effectively prevents officials from commenting publicly on health matters.

I would just like to raise one or two issues from these guidelines and ask the hon the Minister to comment in this regard. In the introduction to

these guidelines it is said that the aim is to influence observers of health services positively and in a co-ordinated way. I say to the hon the Minister that the function of the Minister of National Health is, in fact, to provide health services most effectively. Sometimes we find that health matters are raised through the media, for instance in the case of what was happening at King Edward VIII Hospital last year. It is only when these health issues are raised that those matters are addressed.

In the guidelines negative reporting is mentioned. I would like to ask the hon the Minister what she regards as negative reporting. Is it negative reporting when press reports mention the chronic shortages, for example at King Edward VIII Hospital, which I referred to earlier? I would like to know. Is it negative reporting when a department which is faced with imminent collapse speaks to the Press and informs the public as to what the real situation is? I would also like to ask the hon the Minister whether it is not authoritarian when the person who is charged with this particular function at provincial level says to the media that he, and only he, can comment to the Press. I would like to ask the hon the Minister that very basic question. Is it not better to talk freely with the media? Is it not better for the public to be informed fully? [Time expired.]

*Mr T PALAN: Mr Chairman, thank you very much for the opportunity to participate in this debate.

*HON MEMBERS: Hear, hear!

Mr T PALAN: Sir, from the answers given by the hon the Minister, it is apparent that this document is issued to regulate information to the media on matters of national health only. It also regulates the function of the various health departments and each department's role in its defined areas.

Am I to conclude from this that the various health departments in the different Houses do not speak the same language when it comes to national health, and that we have to have a media liaison office to communicate this kind of information to the Press and the public? If so, then this is a confirmation of the assumption of many people that this tricameral parliamentary system does not work well.

I therefore wish to ask the hon the Minister, in her capacity as Minister of National Health, to propagate an ideology, or at least ask the hon the State President to do away with these three departments and have one ministry for health. Many hospitals, clinics, pensioners and disabled people are crying out because there is a lack of money. In this way, however, we shall be doing our community a great service by taking away additional costs in the various other departments. [Time expired.]

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, I would not approach this topic from the point of view held by my colleague, the hon member for Springfield. However, I want to say that this is a retrogressive step.

Sir, I wonder whether the hon the Minister of National Health is aware of the fact that there was, and possibly is a National Health Policy Council. According to the 1983 Constitution, all Ministers—whether in charge of general affairs or whether in charge of own affairs—have equal status.

A few years ago, the hon the Minister's predecessor launched a grand public relations scheme at a hotel in the Transvaal. It was then decided at Cabinet level that when announcements of national importance or matters relating to health and health services were made, each Minister would enjoy equal status and that such announcements would be made jointly.

Furthermore, there is only one Minister of National Health in this country. The own affairs Ministers are Ministers of health services. After much deliberation it was agreed—even at Cabinet level, by the committee supported by the hon the State President when he was chairman of the Cabinet Committee concerned with social services and Chairman of the Ministers' Council—that every announcement or communication in respect of matters such as health or education, would be made jointly by the Ministers concerned with health or education.

If it is the policy of the National Health Policy Council that each Minister concerned with health has status equal to that of the hon the Minister of National Health who is in charge of general affairs, then—as the hon member for Springfield has stated—it would be a retrogressive step for the hon the Minister of National

Health in the Cabinet to take supreme responsibility, and it would be wrong. [Time expired.]

Mr P GOVENDER: Mr Chairman, with the multitude of health ministries in this country, the potential for conflicting and contradictory policy statements is real.

In view of the sensitivity of the portfolio, it is important that the activities of parallel ministries be streamlined and co-ordinated. This will make for a more efficient utilisation of the country's limited resources. However, these laudable objectives cannot be achieved by fettering the power of own affairs ministries to make statements. What is necessary and long overdue, is the abolition of own affairs health ministries. If the withdrawal of some of the functions is not adversely affecting health care, then the abolition of own affairs ministries would make a positive impact on health care.

Mr M RAJAB: Mr Chairman, although it was never intended, this debate has in fact veered towards own affairs. I would just like to make the following comment. If hon members on the other side of this House really wish to put their money where their mouths are, they should do something more positive about it. They should try to put an end to the own affairs concept as quickly as possible. There is a way out. [Interjections.] There is a constitutional way out. If hon members would like to consult me in this regard, I shall give them free advice.

To return to the document before us, the chairman of the Natal coastal branch of Masa, Dr Fanus du Toit, said, and I quote:

> Masa will never accept gagging from any political authority.

[Time expired.]

The MINISTER OF NATIONAL HEALTH: Mr Chairman, this document does not relate to any private health or other association, therefore this does not concern Masa. This concerns the different departments of health. This is the first point I would like to make. [Interjections.]

I would like to reply to what the hon member said earlier. I would like to stress the fact that we need not select issues from this paper. If one looks at what it says further on, one will find that this document states clearly that health is an emotional matter and that the public is easily alarmed. It is therefore imperative that the public and groups that have an interest in health services should be properly informed. Problems should not be hidden, but should rather be handled with great responsibility so that there is no unnecessary anxiety about the services.

The words "health system on edge of collapse" have been used. We do have problems, but health is not on the edge of collapse.

Mr M RAJAB: Was the King Edward VIII on the verge of collapse?

The MINISTER: I would like to reply to the hon the Leader of the Official Opposition. The principle of this document was approved at a meeting of the National Health Policy Board, at which all Ministers and MECs responsible for health care were present. The principle was discussed and this is an effort to maintain a healthy management practice in the liaison with the media.

This is no effort to stop criticism or to gag any criticism of the health care family. The whole purpose of this is to provide a good channel of communication within the different departments. I should like to refer the hon member to the way in which this is being handled. [Time expired.]

Debate concluded.

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

Own Affairs:

Cato Manor: development

Mr M RAJAB asked the Minister of Housing:

(1) Whether he has received information on a proposal made to the Durban City Council for the development of Cato Manor involving, *inter alia*, the establishment of an independent development agency; if so,

(2) whether he has taken any steps in regard to the matter; if not, why not; if so, what steps?

D9E.INT

(a) it is therefore not possible to give an indication at this stage what the nature of shortcomings are, if any; and

(b) apart from the aforementioned commission steps have already been taken to upgrade the management of the Department. In this regard there was *inter alia* an investigation and recommendations by an independent financial and management consultant Mr Leendert Dekker. Another consultant Mr Steve Rossouw has recently been requested to conduct a further investigation.

(2) As far as the allocation and recommendation of housing loans under the individual self-build schemes are concerned, no irregularities have come to light. Parts (a) and (b) of this question thus fall away.

New questions:

*1. Mr D J Dalling—Justice. [Question standing over.]

*2. Mr J A Jordaan—Law and Order.† [Question standing over.]

Subsidized motor transport schemes

*3. Mr J J WALSH asked the Minister of Development Aid:

(1) Whether officials of his Department seconded to the self-governing territories, participate in subsidized motor transport schemes the terms of which differ from those pertaining to similar schemes for such officials in the Republic of South Africa; if so, (a) which self-governing territories have schemes that differ from comparable schemes in operation in the Republic, (b) in what respects do these schemes differ from those operating in the Republic, (c) why do these differences exist and (d) what is the estimated additional cost of these differences for the 1988-89 financial year;

(2) whether any action is proposed to standardize subsidized motor transport schemes; if not, why not; if so, what action?

B22E

The MINISTER OF DEVELOPMENT AID:

(1) Officials from *inter alia* the Department of Development Aid seconded to self-governing territories participate in subsidized motor transport schemes of which the conditions of some differ from that applicable in the Republic.

(a) KwaZulu, KwaNdebele, KaNgwane, Lebowa and Gazankulu. Qwaqwa do not have a subsidized motor transport scheme.

(b) The official kilometre lifespan of vehicles in Lebowa and KwaNdebele is longer and those of KaNgwane and Gazankulu is shorter than that applicable to vehicles in the Republic. A special allowance per kilometre is granted in some instances for maintenance and the models available to Departmental heads are more expensive than those of their counterparts in the Republic.

(c) These differences exist because the self-governing territories are empowered, under the provisions of the Self-governing Territories Constitution Act, 1971, to make and implement their own decisions in this regard.

(d) The Department cannot calculate the estimated additional costs which occur as a result of these differences because it only has access to figures applicable to schemes that apply with respect to the Central Government departments.

(2) As long as the self-governing territories continue, under the provisions of the Self-governing Territories Constitution Act, 1971, to exist outonomously, these areas may at the utmost, only be advised to bring their schemes in line with that which applies in the rest of the Republic. Discussions with the Secretaries to the Departments of the Chief Ministers of the various self-governing territories have already been held in this regard. The erstwhile Minister of Education and of Development Aid approached the Chief Ministers of the various self-governing territories through the respective Commissioners-General and has suggested that they take it into consideration to

scale down the benefits of their transport schemes in order to bring it in line with those which apply in the Republic.

State lottery

*4. Mr R F HASWELL asked the Minister of National Health:

(1) Whether she has received any petitions and/or submissions regarding a state lottery to finance health services; if so, (a) when, (b) from whom and (c) what was (i) the purport of and (ii) her response to these petitions and/or submissions;

(2) whether she will make a statement on the desirability of a health lottery?

B56E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(a) 25 November 1990 and 20 December 1990,

(b) Mr A V Sacks and the Town Clerk of Pinetown,

(c) (i) to finance medical services, health education, housing and similar services

(ii) referred to the Minister of Justice as the Gambling Act, 1965 is administered by the Department of Justice;

(2) no.

Pietermaritzburg: capital city status

*5. Mr R F HASWELL asked the Minister of Planning, Provincial Affairs and National Housing:

(1) Whether he or any member of his Department has held discussions regarding the capital city status of Pietermaritzburg; if so, (a) when, (b) where and (c) with whom;

(2) whether any decisions and/or recommendations emanated from such discussions; if so, what decisions and/or recommendations; if not, when can a decision be expected;

(3) whether he or any member of his Department intends holding discussions in this regard in the future; if so, when?

B57E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

(1) No, (a), (b) and (c) fall away

(2) falls away

(3) no.

False Bay: pollutants

*6. Mr A L JORDAAN asked the Minister of Water Affairs and Forestry:†

(1) Whether his Department exercises control over pollutants discharging into the sea in False Bay by way of river courses; if so, what control; if not, why not;

(2) whether the pollution levels in the sea in False Bay are monitored; if so,

(3) whether he will make known the results of this monitoring;

(4) whether research is being done on the long-term effects of this type of pollution; if so, what is the nature of this research;

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

B58E

The MINISTER OF WATER AFFAIRS AND FORESTRY:

(1) Yes. The Department of Water Affairs and Forestry exercises control over point sources of pollution discharging into the sea in False Bay, or into estuaries, rivers and streams which flow into the Bay.

In terms of section 21 of the Water Act, 1956 (Act 54 of 1956) a general standard is laid down and any discharge of effluent must comply with that standard. In those cases where it is not regarded as essential that all the parameters be complied with, exemptions from certain requirements and subject to certain specific conditions, may be granted. The general standard and any exemptions are determined by the Department in consultation with, *inter alia*, the Department of National Health and Population Development and the South African Bureau of Standards. The 13 point sources of effluent discharge in False Bay, or the catchment area of the Bay, comply with the exemptions granted

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.

Health 'the community's responsibility'

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.

Training is inadequate, says doctor

Sowetan 25/2/91

By PEARL MAJOLA

MEDICAL training in South Africa does not prepare students to work under the poor conditions prevailing at rural and township health facilities, a leading doctor has said.

Eastern Transvaal obstetrician Dr Eddie Mhlanga, addressing the Lesedi Health Discussion Group conference at Vista University, said: "The environment for training and the facilities available (in medical school) are all not in the real world. In the training institutions, sophisticated machinery receives priority."

When doctors left those institutions and joined facilities lacking such equipment, they found themselves at a loss as to how to treat patients.

He said diseases doctors encountered as professionals bore little resemblance to those they were taught at medical school.

"Is it a wonder then that more than 50 percent of the graduates of Wits and Cape Town leave the country for Australia, Canada, America and Europe?" Mhlanga asked.

He said that those who left were replaced by doctors often recruited from Europe who were not familiar with the health problems facing people in South Africa.

Mhlanga also highlighted the plight of rural health workers and patients. The 266-bed hospital where he was based in the eastern Transvaal had not expanded since the 1970's, he said.

It was overcrowded and in a state of disrepair. More than 80 patients shared two toilets and two showers. Patients often shared beds.

More than 50 mothers died every year during or immediately after childbirth from postpartum bleeding, uncontrollable hypertension or infections.

Mhlanga said Aids was a threat to health workers. He noted that there was no policy holding employers responsible for the safety of health workers.

He also stressed that there should be co-operation between all health workers, including traditional healers and spiritualists.

He urged training institutions, when admitting students, to consider how well they would serve the needs of various communities.

He said currently "as long as one passes matric with good symbols in mathematics, physical science and English there is a place for him at medical school".

Hospital services cut to beat debt of R50m

LESLEY LAMBERT

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.

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.

Free State hospital boss could face ethics probe

B|Day 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

85

B|Day 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. B|Day 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

...strung ...uld be ...30 is a ...consti- ...overn- ...ious is ...ning?" ...eterse ...pres- ...mping ...initia- ...eeting ...er on ...is that ...ring of

...in the township at the weekend.

PICTURE: REUTER

Private health sector 'drains' resources

TANIA LEVY

THE National Medical and Dental Association (Namda) has accused the private health sector of undermining and draining resources from the public sector.

Namda said the private sector was heavily subsidised by the public sector.

In a statement released at the weekend, the association said that in 1987 SA spent 5,8% of GDP on health care, 44% of which was spent in the private sector which cared for about 20% of the population.

Some 80% of the population dependent on public health care were treated with the remaining 56% of expenditure.

It said the current trend towards privatisation of health care promoted an increase in health inequalities.

Namda said proper housing, sanitation and employment were the most important aspects to improving health care.

Reacting to recent cuts in the Cape's health budget, the association said the most needy people, particularly those in rural areas, would be worst affected.

It had to be asked why there was such a huge deficit, making the "cuts" necessary.

Namda said government would always be reacting to crises unless it tackled the issues of fragmentation, privatisation and inadequate primary health care.

Deans react as Wits sit-in goes on

TANIA LEVY

ABOUT 40 Wits students continued their sit-in at the university vice-chancellor's office yesterday in support of demands for improved accommodation, an extension of the deadline for payment of fees and the readmission of failed students.

Student leaders said yesterday protest action would continue until they received a satisfactory response to their demands from university authorities.

On Friday, students burnt tyres at a barricade erected in Yale Road, Braamfontein, occupied the fees administration, and arts and science faculty offices, and erected a symbolic shack on the library lawns to highlight the lack of accommodation, particularly for black students.

Wits's 10 deans of faculty condemned the protest as illegitimate and indefensible.

They said they deplored protesters' intimidation of students, academics and support staff.

While the university had a proud tradition of fighting for the right to legitimate protest, the deans said they could not tolerate protesters denying others' rights to teach, to learn or to pay fees.

Protesting students had invaded the vice-chancellor's privacy by occupying his offices and refusing to leave.

Students occupied the office on Thursday at the start of a class boycott by several hundred students.

Students' demands centre around accommodation shortages, the exclusion of students who failed last year and Friday's deadline for full payment of fees.

Wits vice-chancellor Robert Charlton said he could not accept that any student with a reasonable chance of passing had been excluded.

He sympathised with students who were still without accommodation.

The university was trying to raise funds for a new residence on west campus.

However, the university could not possibly guarantee accommodation for all students, as demanded by the Students Representative Council (SRC) and the Black Students' Transitional Committee (BSTC).

Charlton said R1m in unpaid fees was still outstanding from last year.

Hansard 12/3/91 set aside or alter such order or to issue another order which he may deem just. The procedure to be followed by such a member is set out explicitly in Prisons Regulation number 78. In terms hereof a member who wishes to appeal to the Minister against an order of dismissal or demotion in rank or seniority must within fourteen (14) days of written notification to him of the issue of such order, lodge a notice of appeal in writing to his commanding officer for transmission to the Commissioner. The member concerned must clearly and specifically set out the grounds on which the appeal is based and he may at the same time himself or through his legal representative submit written arguments or representations in support thereof. The Commissioner must then submit the notice of appeal and written arguments or representations together with the record of the proceedings of the inquiry and the findings and reasons of the commissioned officer who conducted the inquiry to the Minister for consideration.

Of the thirty six (36) members concerned six (6) have appealed against the decisions. These applications for appeal are being dealt with at present.

In conclusion I would like to mention that strikes by members of the Department of Correctional Services are seen in a very serious light, in as much that a Bill was passed by Parliament as recently as 1990 making provision for the summary dismissal of members who make themselves guilty of this practice.

Petrol: maximum price

*11. Mr W U NEL asked the Minister of Mineral and Energy Affairs and Public Enterprises:†

(1) Whether he envisages prescribing only a maximum price for petrol in all the fuel zones in the Republic; if not, why not; if so, when;

(2) whether such maximum prices will be calculated on exactly the same basis as the present fixed prices; Hansard 12/3/91

(3) whether this arrangement in respect of a maximum price will also apply to the wholesale price of diesel;

(4) whether consideration is being given to reducing the price of paraffin; if not, why not? Hansard 12/3/91 B417E

The MINISTER OF MINERAL AND ENERGY AFFAIRS AND PUBLIC ENTERPRISES:

(1) In accordance with Government's policy on commercialisation and deregulation, an investigation into Government's involvement in the petroleum industry is also being conducted. The investigation is a comprehensive exercise and is still not fully finalised. The Competition Board was also approached for advice. Any possible change to the existing pricing policy can only be considered after the lifting of oil sanctions against South Africa.

(2) Falls away.

(3) The prices of petrol, diesel and illuminating paraffin have for many years been controlled on wholesale level only as maximum prices.

(4) Yes, an announcement will be made in the not too distant future.

Independent Black states: reincorporation into RSA

*12. Mr A E DE WET asked the Minister of Foreign Affairs: Hansard 12/3/91

(1) Whether the South African Government has been approached by any of the four independent Black states with a view to reincorporation into the Republic; if so, (a) by which states, (b) when and (c) what was the response in each case; if not,

(2) whether the Government will take steps to facilitate the reincorporation of these states into the Republic at the earliest opportunity; if not, why not; if so, (a) what steps and (b) when;

(3) whether he will make a statement on the matter? B431E

The MINISTER OF FOREIGN AFFAIRS:

(1) and (2)

I have already replied to these questions in my response today to question 1 of the interpellation.

(3) No, not for the time being.

Group areas permits: abolishment

*13. Mr L FUCHS asked the Minister of Planning, Provincial Affairs and National Housing:

Whether, in view of the reply by the Minister of Justice to Question No 20 on 19 February 1991 in regard to prosecutions against persons contravening the Group Areas Act, No 36 of 1966, he will take steps to abolish the necessity to apply for group areas permits; if not, why not; if so, (a) what steps and (b) when? B432E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

No. Hansard 12/3/91

In view of the announced repeal of the Group Areas Act, I have requested all institutions which are concerned with the administration of permits, to grant permits on a free basis. No further group areas or free settlement areas will be proclaimed.

(a) and (b) Fall away.

Nurses: salary increase

*14. Mr B B GOODALL asked the Minister of National Health:

(1) On what date did nurses receive their most recent salary increase;

(2) whether radiographers were given a salary increase at the same time; if not, why not; Hansard 12/3/91

(3) whether it is the intention to increase radiographers' salaries in the near future;

(4) whether she will make a statement on the radiography profession in South Africa? B441E

The MINISTER OF NATIONAL HEALTH:

(1) 1 July 1990;

(2) no, the occupational class Radiographer was not identified by the Cabinet for an occupational specific investigation during the 1990/91 financial year;

(3) finality has not been reached yet about which occupational classes' salary structures will be improved during the 1991/92 financial year. An announcement in this respect will be made soon;

(4) no. Hansard 12/3/91

Single department of health

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

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

(2) whether she will make a statement on the matter? Hansard 12/3/91 B446E

The MINISTER OF NATIONAL HEALTH:

(1) The Department of National Health and Population Development is at present in the process of considering various models for the restructuring of health services. Extensive deliberation and consultation by the Department with the relevant role players take place at high level on a continuous basis. In the consideration of the different models various factors, including the administrative, financial and health implications, are taken into account;

(2) no.

*16. Mr P G Soal — Home Affairs. [Withdrawn.]

Johannesburg: rapid rail transit system

*17. Mr P G SOAL asked the Minister of Transport:

Whether, with reference to his reply to Question No 106 on 2 March 1988, a decision has been taken on the introduction of a rapid rail transit system for Johannesburg; if not, why not; if so, what was the decision? B461E

The MINISTER OF TRANSPORT:

No. Upon recommendation of the then National Transport Commission (NTC), the former Minister of Transport approved, in September 1988, a full feasibility study to a mass transit system for the Greater Johannesburg Area. This comprehensive study, which is being conducted by the Masstran Consortium, will include an investigation into a rapid rail transit system as an alternative transport system and is expected to be completed by the end of June 1991. A report will then be

The CHAIRMAN OF THE HOUSE: Order! Could the hon the Leader of the Official Opposition repeat that question?

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, I shall repeat the question. Was the decision of the Housing Development Board in respect of the allocation made during the past two years?

The MINISTER: No, I think it was made in August for the first time.

The LEADER OF THE OFFICIAL OPPOSITION: Sir, it would therefore be correct to assume that no blame could be attached to the previous administration. [Interjections.]

Mr Chairman, further arising out of the answer given to the second part of the question, I would like to ask the hon the Minister whether it would not have been better to have asked the Housing Development Board to review the decision, rather than revoke it.

The MINISTER: Mr Chairman, my concern is to build homes which fall within the limits of this housing administration, because it has been created primarily for this purpose. The decision was revoked, because it concerned a category of people who were earning between R2 000 and R3 500 per month.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, is it not correct that the Housing Development Board only acts on a memorandum of submission made by the hon the Minister's Department?

The MINISTER: Sir, the motivation actually comes from the officials in the Department. In this case I, in my capacity as Minister of Housing, have the overall responsibility. I therefore revoked the decision, because I felt that that land should be used for other purposes.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, does the drastic step of revoking a decision not reflect on the administration of the hon the Minister which advises the Housing Development Board?

The MINISTER: Sir, if an administration acts in good faith, there is nothing wrong if a Minister decides to revoke a decision. After all, he has the overall responsibility. These things happen, but they should be done in good faith.

Mr T PALAN: Mr Chairman, may I ask the hon the Minister if there is a garage site in that area?

The MINISTER: Sir, 399 sites were involved but they were residential sites. However, one could park a car there! [Interjections.]

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Natal health services: amount spent

1. Mr M RAJAB asked the Minister of National Health:

(1) (a) How much of the sum of R50 million which the State President announced in October 1990 was to be made available for health services in Natal has been spent and (b) in respect of what date is this information furnished;

(2) how has this money been allocated?

D17E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Provincial Administration of Natal: Health Services—R15 011 564

KwaZulu Health Services—Nil and

(b) Provincial Administration of Natal: Health Services—15 February 1991

KwaZulu Health Services—4 March 1991;

(2) Provincial Administration of Natal: Health Services—R39 000 000

KwaZulu Health Services—R11 000 000

Own Affairs:

Care of the aged: funds

3. Mr H M NEERAHOO asked the Minister of Health Services and Welfare:

(1) Whether any funds appropriated in respect of the 1990-91 financial year for institutionalised care of the aged have yet to be utilised by his Department; if so, (a)(i) what is the amount involved and (ii) in respect of what date is this information

furnished and (b) why has this amount not been utilised as yet;

(2) (a) how many service centres for the care of the aged are financed by his Department, (b) where is each situated and (c) to what extent is each of them so financed?

D28E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) No.

(a) (i) Falls away.

(ii) 4 March 1991.

(b) Falls away.

(2) (a) Nine.

(b) Verulam Service Centre.
JISS Lenasia.

Aryan Benevolent Home:
Dayanand Gardens
Clayton Gardens

Durban Association for the Aged:
Welbedacht
Phoenix
Chatsworth
Shallcross

Pietermaritzburg Old Age Society.

		Per month
(c)	Verulam Service Centre	R4 111,20
	JISS Lenasia	2 055,60
	Dayanand Gardens	2 341,10
	Clayton Gardens	2 912,10
	Welbedacht	1 884,30
	Phoenix	3 140,50
	Chatsworth	1 998,50
	Shallcross	1 370,40
	Pietermaritzburg Old Age Society	4 568,00

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

Hospital chief needs support rather than censure — Masa

WELKOM — Goldfields regional hospital superintendent Dr Gert van Zyl has been found not guilty of unethical behaviour by the Medical Association of South Africa (Masa).

This follows charges of alleged racial discrimination laid against him by the Goldfields Hospital Desegregation Campaign Committee. The committee laid a complaint last week against Van Zyl for, it alleged, practising racial discrimination in the Welkom, Virginia and Odendaalsrus hospitals.

Masa's Goldfields branch said in a statement that Van Zyl did not, in terms of general patient care, discriminate in his management of hospital patients.

He had inherited the enormous problems of a fragmented health care system and seemed to have done everything possible within financial and administrative constraints imposed on him.

A meeting of Masa's ethical committee on Monday had been impressed with his integrity and commitment to a difficult task, and concluded he needed Masa's support rather than censure.

In Cape Town yesterday, Health Minister Dr Rina Venter asked all four provincial administrators to investigate implementation of policy guidelines on the orderly management of hospital patients laid down by the National Health Policy Council.

She said in a statement this request was a result of media reports on admission of patients to the Welkom Hospital.

As a result of Venter's request, Transvaal MEC for Health Services Fanie Ferreira yesterday ordered a survey at all hospitals in the province regarding the handling and admission of patients.

Free State Health Services MEC Roelf Dreyer yesterday denied allegations that he was resisting instructions from the Health Minister to desegregate his hospitals.

He added he would not bow to calls for his resignation.

Dreyer insisted he was doing his best to carry out government's stated desegregation policy, but that it was a slow process. — Sapa.

CP man is jailed for two weeks

PRETORIA — Conservative Party chief secretary Andries Beyers was sentenced to 14 days' imprisonment in the Pretoria Regional Court yesterday after refusing to divulge the identity of a source in terms of a subpoena served on him under Section 205 of the Criminal Procedures Act.

He was, however, granted bail of R500 pending appeal.

Beyers was subpoenaed following an article in the February edition of CP mouthpiece Die Patriot, which said that a key state witness in the Winnie Mandela trial, Gabriel Pelo Mekgwe, had been kidnapped by the state's intelligence services.

Pretoria magistrate M Kilian said the submission that the President had given the assurance there had not been a kidnapping, and therefore no crime, did not hold water.

He said it was Beyers and his source who alleged there had been a crime, and only a full police investigation could determine if a crime had been committed.

Beyers refused to divulge the identity on the grounds that he had promised not to do so. — Sapa.

Venter on sickly state of the nation

By ANTHONY JOHNSON
Political Correspondent

THE standard of health was deteriorating, the Minister of National Health, Dr Rina Venter, said yesterday.

The latest figures available to the Department of Health were "not pleasant to look in the eye" and showed standards were declining, among coloured people in particular.

Dr Venter was speaking during a debate on a private member's motion on health.

The declining health standards were related to deteriorating socio-economic conditions, she said.

However, 11,7% of the national budget had been spent on health care.

The drop in infant mortality rates among Africans was levelling out — but there had been a "marked deterioration" in general mortality among coloured people.

The incidence of malnutrition was increasing among coloured and African children — and among elderly whites.

Tuberculosis was also increasing, particularly among coloured people and Africans.

Communities had to be made responsible for primary health care.

"I hope to promote a programme of training ordinary people in primary health care."

The problems and the shortage of funds could not be attributed simply to the fragmentation of health services and the own affairs system.

"If you take the tricameral system away tomorrow, we will still be faced with very, very serious problems."

The reasons were rapid population growth, that most Africans were aged under 16 years and a large proportion of whites were aged. Both these groups needed "a lot of care".

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.

with that. Sporting organisations which therefore allow themselves to be taken in political tow, cannot receive the sympathy of the Government.

*Hon MEMBERS: Who are they?

*The MINISTER: I will not identify them. I am saying that a specific political activity can be seen in the present organisation of sport and it would be wrong for the Government to close its eyes to that political interference. When the Government did act and interfered in sport, this had negative consequences, and now we expect sport administrators to concentrate on sport, act independently and not allow themselves to be taken in tow by the politicians who also want to use sport for their own objectives and purposes.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

*1. Mr A J Leon—Law and Order. [Question standing over.]

All departments of health: control

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

(1) Whether she intends taking steps to take control of the departments of health in both the House of Representatives and the House of Delegates; if so, what are the relevant details; if not, why not;

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

B452E

†The MINISTER OF NATIONAL HEALTH:

(1) No, in terms of the Republic of South Africa Constitution Act, 1983, health is regarded as an own affair and the responsibility is therefor vested in the relevant own affairs administrations;

(2) no.

†Dr W J SNYMAN: Mr Chairman, arising out of the hon the Minister's reply, I would just like to ask which hospitals in South Africa still fall under so-called own affairs for Whites, and on what grounds—against the background of the present policy of the Government—they still are regarded as own affairs hospitals.

†The MINISTER: Mr Speaker, it is a new question that does not involve this question. [Interjections.]

†The ACTING SPEAKER: Order!

†The MINISTER: The hon member can put that question on the Question Paper and I can provide all the names of the hospitals on a list. [Interjections.] There are 44 hospitals if the hon member wants me to name them.

†Dr W J SNYMAN: Mr Chairman, further arising out of the hon the Minister's reply, and according to her own explanation hospitals or health services in terms of the Constitution fall under own affairs. How can it then be explained that hospitalization, for instance, is available to all groups?

†The MINISTER: Mr Speaker, the question to the Minister is whether the Minister intends to take over own affairs from the House of Delegates and the House of Representatives. The answer is no.

The matter of whether hospitals fall under own affairs, is a new question. The hon member can put it on the Question Paper and then I will answer him. [Interjections.]

†Dr W J SNYMAN: Mr Chairman, further arising out of the hon the Minister's reply, I specifically would like to know with regard to the House of Delegates and the House of Representatives whether any health affairs fall under these Houses.

†The MINISTER: Mr Chairman, the question on the health affairs that fall under those Houses can be put to those hon Ministers. [Interjections.]

Political violence: deaths

*3. Mr R V CARLISLE asked the Minister of Law and Order:

(a) How many persons died in or as a result of political violence during the 1990 calendar year and (b) how many such persons were members of the South African Police Force?

B465E

The DEPUTY MINISTER OF LAW AND ORDER:

To answer the question, particulars will be furnished of persons who died in 1990 as a result of unrest. These deaths did not necessarily result from political violence. There were also incidents where clashes occurred between persons and groups of persons which did not necessarily relate to political ideologies and/or actions. The differences between such clashes and political violence can therefore not always be determined.

In view of this, the particulars are as follows:

(a) 2 675 persons.

(b) 68 members.

†Adv J J S PRINSLOO: Mr Speaker, arising out of the hon the Deputy Minister's reply, I wish to ask whether he wants to intimate that the Government is unable to distinguish, on the basis of scientifically-founded criteria, between unrest-related or political violence and other violence.

†The DEPUTY MINISTER: Mr Speaker, the answer is clear. In 2 675 of these cases this distinction could be drawn. In a few of these cases it was not easy to draw such a distinction. The SA Police have been able to draw that distinction to this extent on the basis of scientific research at their disposal, as well as on the basis of observations and surrounding circumstances.

†Adv S C JACOBS: Mr Speaker, further arising out of the hon the Deputy Minister's reply, in which cases is it easy to draw this distinction and in which cases is it not?

†The DEPUTY MINISTER: Mr Speaker, the answer is as simple as the question. In cases in which it is clearly identifiable that unrest or political violence was the cause of deaths' in such situations and to such extent it is possible to classify such deaths in that category. In all cases in which they can be classified as ordinary murders, where politics is not the motif, it is also easy to classify them as such.

†Adv C D DE JAGER: Mr Speaker, further arising out of the hon the Deputy Minister's reply, is it possible for him to indicate to us how many of the 68 policemen who died, had been called out to a fake ambush and were consequently killed? [Interjections.]

†The DEPUTY MINISTER: Mr Speaker, if the hon member is speaking of a fake ambush I do not know whether he means that there was no ambush, because one either has an ambush or one does not. If one had a fake ambush, one did not have an ambush. [Interjections.] The SA Police have particulars of all the circumstances under which members of the Police Force were killed. These also include the 68 members. Unfortunately I cannot identify all 68 for him this afternoon.

†Adv J J S PRINSLOO: Mr Speaker, further arising out of the hon the Deputy Minister's reply, the gist of his reply is that we cannot say how many of those 68 policemen were killed as a result of political violence. Because that was the question, we would like to know how many of those 68 policemen were killed as a result of political violence and how many were not. [Interjections.]

†The DEPUTY MINISTER: Mr Speaker, the hon member now asks me whether the Police is unable to say how many members were killed as a result of political violence. The answer has been given: 68 members of the SA Police were killed under these circumstances. I do not know what the purpose of his question is. [Interjections.]

Mr R V CARLISLE: Mr Speaker, arising out of the hon the Deputy Minister's reply, with those kind of figures, which indicate that we are close to some form of anarchy, is he satisfied that, firstly, the situation can be contained and, secondly, it can be improved upon in the following 12 months?

†The DEPUTY MINISTER: Mr Speaker, the SA Police are not at all happy with this state of affairs and will do everything in their power to contain and handle this situation in an effort to reduce the figures given here today. The responsibility to curb conflict in this country does not, however, rest only with the SA Police. It is also, to a great extent, the responsibility of the leaders of those political groups which are in constant conflict with one another. It is also a political responsibility, and the Police also want to appeal to the leaders of those political parties to keep their followers under control. [Interjections.]

The ACTING SPEAKER: Order! There will be no more supplementary questions on question 3,

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

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,"

WILSON ZWANE

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.

Outlay on buying land for homelands is slashed 76%

CAPE TOWN — Government spending on the purchase of land for the homelands is to be slashed by 76% from R53,5m to R12,7m during the 1991/92 financial year.

But expenditure on the 10 homelands is to increase by 24,7% to R9 811,5m.

No provision has been made for the purchase of properties in the four independent homelands, an item which cost R15m last year. B Dan 21/3/91

The cuts in expenditure come in the wake of government's White Paper on land reform, in which it said the law under which land was to be purchased for the homelands, the 1936 Development Trust and Land Act, was to be scrapped.

Enormous sums of money have been spent over the years for the purchase of land to consolidate the homelands.

This item will now disappear from the Budget, and the R12,7m in the 1991/92 financial year is likely to cover commitments which government has already made for the purchase of property.

The Estimates of Expenditure, which

Political Staff

was tabled in Parliament last year, make provision under the Foreign Affairs vote for budgetary aid to the independent homelands of Transkei, Bophuthatswana, Venda and Ciskei to go from R2 644,9m to R3 551,9m.

A further R86m has been set aside for the industrial incentive schemes in the TBVC states and R13,6m for "ad hoc grants", for which R6,1m was budgeted last year.

However, no details were provided of how much would be transferred to each of the TBVC states.

Under the Development Aid vote, R6 160m has been provided for the six non-independent homelands, compared with the R5 129,9m budgeted last year.

KwaZulu is to get R2 736,7m, Lebowa R1 578,2m, Gazankulu R773,9m, KaNgwane R413,2m, KwaNdebele R333,7m, and QwaQwa R313,1m.

Health spending goes up by nearly 9%

CAPE TOWN — Government spending on health services would increase by 8,9% to R8 175bn in 1991/92, with greater emphasis placed on primary health care, said Finance Minister Barend du Plessis. 85

But despite the change in emphasis on health spending, only 5% of the health budget would go to primary health care, Du Plessis said. B Dan 21/3/91

"Experience has shown that the health status of a community is influenced to a significant degree by expenditure outside the strict health field, for example in the supply of water for domestic use, sewerage, housing and balanced nutrition.

Political Staff

"Various measures for which funds are being supplied in this Budget ... therefore indirectly support the function of primary health care," he said.

Du Plessis said the private sector continued to devote itself to more specialised curative services "for that portion of the population that can bear economic tariffs".

He said what the private sector spent on health services already represented about 45% of the total.

om the surplus of the previous financial year meet its financing requirement.

AX PROPOSALS:

VAT will be introduced at 12% on September).

Company tax: The nominal company tax ıte will be reduced from 50% to 48% in the rst step towards the goal of a 40% tax rate. owever, the removal of tax concessions will esult in a higher effective tax.

Personal tax: The maximum marginal tax ıte for married men will be cut from 44% to 3% and the primary rebate will be reduced om R2 100 to R2 000.

The maximum marginal tax rate for mared women remains unchanged at 38%, while ıe primary rebate will increase from R700 to 800. Married women over the age of 65 will ecome eligible for the additional rebate of 2 100. Separate taxation will be fully phased ı this year with the separate taxation of inestment income.

Life assurance industry: The tax rate will be educed to 43%, the same level as the maxiıum marginal rate for individuals.

Mining industry: The lower tax formula for old mines recommended last year will be ılly implemented this year and step three of ıe phasing out of the surcharge on non-gold ıines will proceed.

Marketable Securities Tax and Stamp Duty: MST will be reduced from 1,5% to 1% of the purchase price of a security, while stamp duty on the transfer of unquoted marketable securities will be reduced from 15c to 10c. Both will be phased out over three years.

IMPORT SURCHARGE:

- ☐ Capital goods will be cut by half to 5%.
- ☐ Intermediate goods will be reduced from 7,5% to 5%.
- ☐ Less essential consumer goods will be maintained at 40%.
- ☐ White goods will be maintained at 15%.

CUSTOMS AND EXCISE:

- ☐ Beer will increase by 3c a bottle of 340ml or "dumpy".
- ☐ Spirits will increase by about 1,5c a tot, or 37,7c a 750ml bottle.
- ☐ Cigarettes will increase by 3c for 10 cigarettes.
- ☐ Cigarette tobacco will increase by 3c per 50g.
- ☐ Pipe tobacco and cigars will increase by 25c per kg.
- ☐ Fortified wine and sparkling wine will increase by 1,8c per 750ml bottle.

LAST YEAR'S SURPLUS: R1bn has been allocated to government pension funds, R450m to the Export Credit Reinsurance Fund, R350m to the Maize and Grain Sorghum Boards and the remaining R206m to the 1991/92 fiscal year.

LESLEY LAMBERT

Spending on housing 'must be accelerated'

Political Staff

CAPE TOWN — Beefed up housing schemes should allow an additional 90 000 families to acquire housing or a serviced stand in the new financial year, says the Budget review.

However, the actual amount provided for housing in the Budget dropped from the R1,208bn in the 1990/91 financial year to R1,087bn in the coming financial year.

An additional appropriation of R60m for housing expenditure is also proposed for the House of Representatives.

The review points out, though, that these amounts are not strictly comparable for purposes of evaluating the progress of low-cost housing, inasmuch as certain off-budget loci have come into existence that provide various forms of financing in this field.

The review takes note of the serious housing shortage and says it could get worse. B Dan 21/3/91

It said it was estimated that more than 1,6-million people could be regarded as squatters, as defined at present, while another 1,7-million lived in backyards.

The review says state spending on housing must accelerate and adds that a "leverage mechanism" must be devised in respect of private sector funds to deal with backlogs.

It noted that the Independent Development Trust had recently announced that R375m would be made available in each of the following two years for housing.

In addition, it was proposed that the R119m remaining from the R250m allocated in 1990/91 for the purchase of land for black urbanisation, be voted in the additional appropriation for 1991/92. This was to have been funded out of the proceeds of privatisation.

It was further proposed that a supplementary R90m be voted for the Department of Planning, Provincial Affairs and National Housing to supply basic infrastructure.

Shot in the arm for health spending

Sfar 21/3/91 (85)

TOTAL spending on health goes up 8,9 percent to R8,1 billion and will account for 9,8 percent of overall Government expenditure.

However, less than 5 percent will go towards primary health care, an area Barend du Plessis singled out yesterday as the sphere for increased Government activity in future.

The State's responsibility would shift increasingly towards "the provision of primary health care services and the delivery of more affordable curative health services for the needy".

Development in other fields such as housing, nutrition and proper services also had a "supporting function" in improving primary health.

The private sector continued to specialise in curative health services for that portion of the population that could bear the economic tariffs.

The Budget Review says more affordable health delivery for the broad South African community would continue to rest strongly on a partnership between the State and the private sector. □

R220-m aid for 'severely indigent'

Star 21/3/91 (86)

THE GOVERNMENT is allocating a special amount of R220 million in the Budget for aid schemes for the "severely indigent", Finance Minister Barend du Plessis said yesterday.

The aid will consist largely of food but will also include basic medical services and the provision of clean water.

The R220 million allocation is to be placed in a special account.

The Government is investigating ways of bringing private agencies into the running of the scheme — without jeopardising their independence.

The special targeted groups are to be pre-school children and expectant and lactating mothers, children six to 12 years old, the aged and other social dependents, and some unemployed.

The Budget Review says there is evidence that undernourishment has "already assumed critical dimensions in some cases".

"Limited food intervention programmes are indicated for the survival of certain segments of these exposed target-groups."

The best way to fight poverty is economic growth, but results cannot be obtained overnight and therefore supporting schemes are needed, the Review notes. □

Health budget a cut in real times

Star 21/3/91

85

By Carina le Grange
Medical Reporter

The Government's 8,9 percent increase in health expenditure announced by Finance Minister Barend du Plessis was in fact a decline in real terms, the director of the Centre for Health Policy Studies of the University of the Witwatersrand, Cedric de Beer, said yesterday.

"The increase is less than the rate of inflation, meaning a decline in real terms," Mr de Beer said.

The Democratic Party's spokesman on health matters, Mike Ellis, agreed, saying: "This is no real increase if the rate of inflation (14,3 percent) is taken into account."

The health expenditure announced by Mr du Plessis rises to R8,1 billion from R7,06 billion last year. The allocation to health accounts for 9,8 percent of overall expenditure.

Representative Association of Medical Schemes executive director Rob Speedie said the introduction of value added tax would add R536 million annually to the country's private health care bill.

Rob Speedie ... VAT will add R536 million annually to SA's private health care bill.

Conservative Party health spokesman Dr Willie Snyman expressed disappointment about the budget since it affected the "whole population and the standard of medical care".

Dr Snyman said provincial and academic hospitals would suffer due to the financial curbs, which would affect curative services.

"With the increase in prices, inflation and the unfavourable exchange rate, this could only be considered to mean a back-sliding of conditions," Dr Snyman said.

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

Month	Male	Female
May	102 160	45 545
June	100 576	44 417
July*	209 077	
August*	229 723	
September	160 844	66 354
October	157 557	64 858
November	159 125	60 278
December	164 238	61 844

*Detail not available.

Whites/Coloureds/Indians unemployed

190. Mr P H P GASTROW asked the Minister of Manpower:

How many Whites, Coloureds and Indians, respectively, were registered as unemployed in each inspectorate area as at 31 December 1990? B519E

The MINISTER OF MANPOWER:

Registered unemployed as at 31 December 1990:

Region	White	Coloured	Indian
Central Areas	4 262	2 860	15
Eastern Cape	3 183	4 881	102
Natal	6 483	1 858	8 072
PWV-Central	5 091	4 708	1 201
PWV-North and North-Eastern Transvaal	5 389	586	151
PWV-South	4 829	907	225
Western-Cape	5 723	24 771	30

Medical schools: Black students

205. Mr M J ELLIS asked the Minister of National Education:

How many Black students were studying in each medical discipline at each medical school in South Africa as at the latest specified date for which information is available? B552E

The MINISTER OF NATIONAL EDUCATION:

The table below shows a headcount of Black students enrolled at the various medical schools of the universities in South Africa in 1988.

University	Medicine & Surgery	Dentistry	Nursing	Veterinary Science	Pharmacy	Other
Cape Town	39		2		7	10
Durban-Westville		3		4		15
Medunsa	650	166	162	53		
Natal	242		32			164
North			73		1	19
OFS			1		126	17
UPE			19			
PU for CHE			10		2	
Pretoria						
RAU			4		2	1
Rhodes						
UNISA			3 093		27	
West-Cape		28	2			
Wits	134	15	35		36	11
Zululand			164		17	82
	1 065	212	3 597	57	218	319

Crayfish

230. Mr R J LORIMER asked the Minister of Environment Affairs:

(1) What quantity of crayfish was caught by (a) commercial fishing companies and (b) private holders of fishing licences in 1989 and 1990, respectively;

(2) whether any changes are envisaged in quotas granted to commercial fishing companies; if so, (a) what changes and (b) when will they be introduced;

(3) what are the dates of the 1991 season for the catching of crayfish in South African waters;

(4) whether this season will be adhered to by his Department; if not, (a) why not and (b) what deviations are envisaged?

B609E

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) (a) 1988/89:
West Coast Rock lobster: 4 000 t whole mass
South Coast Rock lobster: 450 t tail mass

1989/90:
West Coast Rock lobster: 3 493 t whole mass
South Coast Rock lobster: 450 t tail mass

(b) 1989: Unknown 1990: Unknown

(2) Yes

(a) Quotas are adjusted upwards or downwards each year in accordance with scientific advice.

(b) Before the start of each fishing season.

(3) North of the mouth of the Olifantsriver:
15 October 1990—30 June 1991
Between the mouth of the Olifantsriver and Yzerfontein:
1 November 1990—30 June 1991
South of Yzerfontein:
15 November 1990—30 June 1991

(4) Normally yes

(a) Not applicable

(b) no deviations are envisaged but an extension to 31 July 1991 may be considered upon request only in the southern area 8 (Cape Point), because the rock-lobster there come into berry later than in other areas.

Own Affairs:

Schools: enrolments

34. Mr A GERBER asked the Minister of Education and Culture:†

(a) How many pupils were enrolled in schools under the control of his Department as at the latest specified date for which figures are available and (b) what amount was appropriated for his Department for the year in respect of which the above-mentioned figure is furnished? B511E

The MINISTER OF EDUCATION AND CULTURE:

(a) *890 042 for 1990,

(b) R3 092 106 000 for the 1990-91 financial year.

*Grade 1 to Standard 10 (special schools included).

Technical colleges: admissions

35. Mr R M BURROWS asked the Minister of Education and Culture:

(1) What number of persons of each population group was admitted to technical colleges under the control of his Department with effect from 1 January 1991 or the latest specified date for which this information is available;

(2) what policy is currently applicable regarding the admission of students of population groups other than White to technical colleges and hostels of such colleges?

B531E

The MINISTER OF EDUCATION AND CULTURE:

(1)

White	Coloured	Indian	Black
48 704	239	88	415

More patients bank on their own blood

Sfer 28/3/91. (85)

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 GRANGE

Hospitals not cured of apartheid's ills

South 28/3 – 3/4/91 (85)

The fact that black patients can now be admitted to white hospitals has not signified the end of apartheid at hospitals, a recent study has concluded. Many decisions governing the treatment of patients are still being based on racial criteria. Chiara Carter reports:

A STUDY of hospitals in the Transvaal has questioned the extent to which apartheid measures have been removed from South African hospitals.

The investigation, conducted by the Centre for Health Policy at the University of the Witwatersrand, followed the announcement that hospitals would be open to all by the Minister of National Health and Population Development, Dr Rina Venter, in May last year.

In her announcement, Venter said there was a surplus of 11 700 beds in white hospitals and a shortage of 7 000 beds in black hospitals.

Excess beds

She said there were no statutory restrictions preventing any patient being admitted to any hospital and no patient could be refused hospital care on the basis of race.

The study points out that the statement did not commit the authorities to full integration or ending segregation in wards.

Instead, it said no black person could be turned away from a white hospital and excess beds should be made available to blacks if necessary.

Interpretation of the policy was left to the individual hospital superintendents.

The statement left open the option of segregated wards and by giving preference to people from the community where the hospital is situated, it means in effect that residents in townships could be discriminated against.

Evidence

Based on an investigation of six hospitals in the Pretoria — Witwatersrand area, the study argues that while there has been some progress in the admission of black patients to hospitals previously characterised white, the process has been "slow, inconsistent and uneven", and that there is strong evidence that apartheid is alive in several provincial hospitals.

While the Johannesburg and JG Strijdom hospitals made rapid strides with a noticable increase in the rate of admission of black patients, at Edenvale, Kempton Park and Pretoria West hospitals progress was extremely slow.

The study points out that the admission of black patients should not be seen as the end of apartheid at hospitals.

Rina Venter

The investigators found evidence of substantial segregation between and within many hospitals and that many of the decisions governing the treatment of patients were based on racial criteria.

The Boksburg/Benoni and HF Verwoerd Hospitals admit patients of all races but house them in racially segregated wards.

The Far East Rand Hospital is separated into two hospitals — one for whites and the other for blacks.

At both these hospitals, private black patients can be admitted to the white section and this makes it likely that patients in the white section receive better treatment than those in the black wards.

Separate

In Krugersdorp, black patients are admitted to a separate hospital to whites.

Doctors working in Alexandra township experience difficulty referring patients to Edenvale, the nearest hospital, because it is considered whites-only.

Staff at Tembisa Hospital claim ambulances continue to bring black patients from as far as Sandton and Alexandra to Tembisa, bypassing two white hospitals, Edenvale and Kempton Park, on the way.

The study concludes that except in a few instances like Groote Schuur, Johannesburg and JG Strijdom, admission of black patients to state hospitals in South Africa are the exception rather than the rule and where such admissions do occur, there are often other apartheid measures within the hospital.

The study says the process of implementing health policy is slow with extremely confused lines of responsiblity and accountability.

While the minister said the policy was immediately operative, she spoke of a management model which was only available in October.

Refused

The minister made it clear that policy interpretation rested with superintendents.

However, the superintendents refused to provide any information without the permission of the province, who in turn said the responsibility rested with the superintendents.

The study says the open hospitals policy has not been enthusiastically implemented; there has been no media campaign to ensure the public understands facilities are open; there is no formal grievance procedure for a member of the public to follow if discrimination occurs; and there appears to be little attempt to monitor whether hospitals are really being opened.

The study recommends that the Department of National Health and Population Development formally adopt and announce a policy of desegregation of all health facilities, including the wards and casualty departments.

'Don't pay hospital fees' call

C1 Press 31/3/91

By SOPHIE TEMA (85)

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

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 Organisaation'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

Help squatters, doctors told

ST Times 14/4/91 (85)

By CAS St LEGER

AN ANC document on health policy suggests doctors and nurses should be sent to rural and squatter areas on compulsory service.

The ANC says: "Many of the poor areas of the country ... experience a serious shortage of health workers.

"One way of dealing with this is to have a period of compulsory service in these areas for all health workers."

The document will be discussed at the ANC congress in June.

Problems

The Medical Association of SA fully agrees with the concept of community health service — with the proviso that it is voluntary.

Dr Bernard Mandell, chairman of the MASA federal council, said: "MASA agrees there is a maldistribution of doctors in this country and supports the principle of community service.

"However, when MASA consulted its special interest group, the Junior Doctors' Association of SA, it became clear that although they also support this principle, certain practical problems in its implementation were foreseen."

Among the problems were married women who would be separated from their families.

A community service system is also being contemplated by the Medical and Dental Council of SA.

Dr Mandell said the association's vision of health care was similar to that of the ANC: an affordable, non-racial, comprehensive unitary health system to which all would have equitable access.

The right to free essential health care should be incorporated in the constitution and bill of rights, the ANC document suggests.

The document also says health care in this country disregards the existence of traditional healers. "This service cannot be wished away," it says.

"It is imperative to develop an appropriate relationship between traditional healers and the rest of the health service."

Dr Mandell said MASA's science and education committee was investigating the relationship between traditional healers and scientific medicine because of the vital role healers played in the culture of many people.

Improved

The private sector, the ANC said, should become part of the national health system. "This means in the short term it will be necessary to find ways to regulate the high cost of private health care."

The public service should be strengthened, improved and made accountable to the communities it served. It would be necessary to attract back into the public sector many of those health workers who had opted for private practice.

The ANC said health and welfare services were so closely linked they should form part of a single Ministry of Health and Social Services.

(4) whether he will make a statement on the matter? B680E

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) No reports had been made by the National Parks Board to the Department of Environment Affairs of copper poisoning in animals in the vicinity of Phalaborwa, but, following the submission of the question, enquiries were made, and an occurrence of possible copper poisoning during the early part of 1989 has now been reported.

(2) In the investigation carried out by consultants on behalf of Phalaborwa Mining Company, the National Parks Board, the Department of Mineral and Energy Affairs, the Department of Health as well as Onderstepoort were consulted. The investigation proved inconclusive in determining the exact area of the occurrence.

(3) Steps have been taken by the Phalaborwa Mining Company to avoid dust distribution during repairs to dust control equipment, which might have been a contributing factor.

(4) Since 1989 there has been no further evidence of copper poisoning in the area concerned.

Principal specialist: representations

*26. Miss M SMUTS asked the Minister of National Health: B686E

(1) Whether she has received any representations on the implementation of the post of principal specialist; if so, for whom;

(2) whether she intends to allow appointments to the post; if not, why not; if so, when?

The MINISTER OF NATIONAL HEALTH:

(1) Yes, The Medical Association of South Africa, The Committee of Deans: Medicine and The Public Servants Association of South Africa;

(2) yes, as from a date not before 1 July 1991.

Mr Joe Verster: SADF

*27. Lt-Gen R H D ROGERS asked the Minister of Defence:

(1) Whether Mr Joe Verster has been re-employed by the South African Defence Force; if so, (a) why and (b) in what capacity;

(2) whether Mr Verster was instructed by his superiors to co-operate with investigations into the activities of the Civil Co-operation Bureau; if so, what are the relevant details;

(3) whether any disciplinary or criminal action is envisaged against Mr Verster as a result of his refusal to co-operate with investigations into the activities of the Bureau or for any other reasons; if so, (a) what action and (b) for what reasons? B688E

The MINISTER OF DEFENCE:

(1) Mr Joe Verster was reinstated in service in terms of his original contract of service.

(a) It was done on legal advice.

(b) As an employee.

(2) Yes, he was instructed to co-operate.

(3) (a) and (b) Yes. Civil proceedings have been instituted against him. The taking of criminal action rests with the Attorney-General.

Life orientation

*28. Mr A GERBER asked the Minister of National Education:†

(1) Whether a policy proposal has been made in his Department in terms of which *inter alia* Biblical instruction and Biblical science are to be replaced by a field of study called life orientation; if so, what are the relevant details;

(2) whether he will make the document concerned available to members of Parliament; if not, why not; if so, (a) in what way and (b) when;

(3) whether he will make a statement on the matter? B690E

The MINISTER OF NATIONAL EDUCATION:

(1) No. The press report according to which Bible Education and Biblical Studies would be phased out, was incorrect. Biblical Studies remains an optional examination subject and Bible Education remains a subject within the Life Orientation field for learners whose parents so desire.

(2) No. The working documents applicable to the revision of the policy regarding curricula for school and college education and from which wrong deductions were made, cannot be made available at present. A full statement will be made in the near future regarding school and college curricula.

(a) Lapses

(b) Lapses

(3) A media statement was released on 28 March 1991 and is attached.

MEDIA RELEASE BY ADV LOUIS PIENAAR, MP, MINISTER OF NATIONAL EDUCATION, ON 28 MARCH 1991 CONCERNING THE FUTURE OF BIBLICAL STUDIES AND RELIGIOUS INSTRUCTION AS SCHOOL SUBJECTS

According to the Minister of National Education, Adv Louis Pienaar, there is no basis to speculation that Biblical Studies and Religious Instruction may be omitted from a revised broad curriculum that is being developed for primary and secondary schools. He emphasised that these allegations derive from unjustified conclusions that were drawn from working documents of a technical committee and that no decisions on this matter have been taken by him or his department.

Mr Pienaar pointed out that more than three quarters of all South Africans are of Christian persuasion and that parents' preferences concerning Religious Instruction will be fully respected in the development of a revised broad curriculum. Religious freedom will likewise be respected.

According to him, pupils will also be free to offer Biblical Studies as an academic subject for matric.

A new dispensation will therefore accommodate both Biblical Studies and Religious Instruction, and the continued presentation of these subjects is in no sense threatened. He indicated that announcements concerning a proposed revised broad curriculum for schools will be made in the near future.

*29. Mr J van Eck — Law and Order. [Question standing over.]

CCB: disciplinary codes

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

Whether members of the Civil Co-operation Bureau were subject to (a) the Military Disciplinary Code and (b) any other disciplinary codes applicable to servants of the State; if not, why not; if so, (i) to which disciplinary codes and (ii) to what extent? B708E

The MINISTER OF DEFENCE:

(a) No, because they did not belong to any of the categories of persons referred to in sections 77(3) or 104(5) of the Defence Act, 1957 or Section 2(1) to the First Schedule of that Act.

(b) No, because they were not "officers" as defined in the Public Service Act, 1984. (i) and (ii) fall away.

Ratio of educators to administrators

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

(a) What is the ratio of educators to administrators in the education departments in the Republic and (b) what categories are defined as (i) educators and (ii) administrators in calculating this ratio? B709E

The MINISTER OF NATIONAL EDUCATION:

(a) The ratio of educators to administrators in the education Departments in the Republic in 1990 was:

Educators:	78,4%
Administrators	21,6%

(b) (i) Educators on post level 1 to 5 were calculated as educators. These educators occupy ranks up to the level of Principal.

(ii) On the grounds that administrators do not stand in a direct teaching relation to learners:
Educators on post level 6 and 7, other personnel than educators, and service workers.

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.

'Too much spent on private health'

Star 18/4/91

By Carina le Grange
Medical Reporter

Private health care "directly undermines" public health care by consuming a disproportionate share of financial and human resources, Dr Jonathan 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 "Health care in a post-apartheid South Africa", at the Executive Seminars' cost-effective health care conference.

In 1989, 46,7 percent of total health expenditure was spent on private-sector care, covering little more than 20 percent of the population, he said.

The other 53,3 percent had to find the remaining 80 percent of the population.

Recent 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.

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.

Health services: Integration 'vital'

By VIVIEN HORLER
Weekend Argus
Medical Reporter

A CRITICAL need for an integrated health service exists in towns and cities, says the Medical Research Council after studying the results of a three-year investigation into the effects of urbanisation on health.

The council's report, which has been handed to the President's Council and was released yesterday, highlights problem areas including poverty-related diseases, diseases related to underdevelopment and poor environmental conditions, malnutrition, violence, smoking, and mental strain due to living conditions.

The report, compiled by the MRC's Centre for Epidemiological Research in Southern Africa, said that in a comparative study of living conditions in the world's 100 largest cities, conditions in Cape Town and Johannesburg were labelled "fair", ahead of Manila, Alexandria, Bangkok, Cairo and Lagos, but behind Ankara, Beijing, Buenos Aires and Caracas.

Cape Town had the highest annual murder rate, and both South African cities did particularly poorly in terms of amount of living space and housing standards (which measured the percentage of homes with water and electricity).

The report's major recommendation was for holistic planning in metropolitan areas, something that had been "sorely lacking".

"Management of the city as a single entity to overcome the adverse effects of fragmentation of services is critical for improving health and other aspects of urban life," said the report.

In another section it stated: "Making health care the responsibility of a metropolitan group would minimise fragmentation, allow for the provision of a number of services that currently are neglected because they fall through the gaps that exist between preventive and curative services, and result in the more effective use of personnel currently restricted to providing preventive care only ...

"The inter-relatedness of all factors in the city, particularly housing, employment and education, means that a central focus on health care is doomed to failure unless it is planned between the different sectors."

Among the major areas investigated by the research teams, led by Dr Derek Yach and Dr John Seager, are:

● Newcomers to peri-urban areas, such as Khayelitsha, run a high risk of illness, both physical and mental, and these people need to be identified. In a major measles immunisation campaign in Khayelitsha, only 71 percent of the children were reached.

The report said innovative ideas, such as shops being used as vaccination points as had happened in Alexandra in Johannesburg, should be developed.

● Tuberculosis rates, which had been declining in the Western Cape, started rising again between 1980 and 1985, against worldwide trends even in countries with very poor TB control measures. This is unlikely to be linked to an increase in Aids infection here, as it is linked in the United States. As many as 80 percent of the South African adult population carry dormant TB, which could develop into active TB if the patient became HIV-positive.

● Diseases such as gastro-enteritis and acute respiratory infection are major causes of childhood death. A study showed that three factors in the home are related to health and safety: overcrowding, adequate clean water and sanitation, and the quality of the shelter. Environmental risk factors, such as poor water and sanitation, use of wood and coal for cooking and heating, need attention.

● Nutrition. There is a critical need for a national nutrition policy, because it is likely that South Africa will follow the example of countries such as Zimbabwe and Sudan in which birth mortality rates are dropping, but the proportion of malnourished and stunted children is growing. In study done in Site B, Khayelitsha, in children under six, 16,8 percent were underweight for their age, wih 23,5 percent being stunted and 2,5 percent wasted.

● Violence and trauma. Assaults accounted for half of the more than 145 000 people who went to hospital in the Peninsula in 1988 with fresh injuries. In road accidents countrywide, the fatality rate is just under 12 for every 100 million kilometres — four times or more that of developed countries.

Referring to political violence, it was found that in Cape Town there was a marked drop in the level of preventive care after riots. "There is a need for health planners to recognise that such periods of unrest are likely during the current process of political restructuring and there is a need to plan effectively to limit the disruption to health services."

● Mental health. A comparative study between elderly people in well-established Langa and Khayelisha found a great deal more psychological stress and depression among the people living in Khayelitsha, especially women.

● Women who have migrated to the cities have been identifed as "one of the most vulnerable groups in the peri-urban areas". In a study on migration patterns among people in Khayelitsha, 45 percent of 659 women were unemployed, with 66 percent of those who were working doing domestic service.

● Health care. Research is needed to determine the best mix of primary, secondary and tertiary hospitals in an area. It is also needed into ways of overcoming fragmentation and into how best to move resources from major hospitals to primary care clinics. Studies at a large hospital had shown that inadequate referrals from primary care clincis led to the swamping of the major hospitals, which then expanded and needed a bigger share of the health budget.

There is a need for more primary health care, especially for children, as a means of providing equitable, accessible, efficient and cost-effective care.

Picture: LEON MÜLLER, Weekend Argus.

Groote Schuur Hospital nurses took part in a parade depicting uniforms from Florence Nightingale's era to the future. The show was held as a tribute to the South African nursing profession, which celebrates its centenary this year. From top left: Terry Babst, Theresa Japhta, Gabieba Mobara, Susan Bartonhill (future nurse), Cindy Barker, Paulita Cloete (kneeling, left), Jacqueline Breugem (kneeling, right), and Maureen Rorke, front.

Medical Notes

Bid to give local authorities more duties

Star 25/4/91.

The Ministers' Council: House of Assembly has in principle approved a plan to investigate the possibility of devolving certain own affairs primary health care services, previously provided by the Department of Health and Welfare, to local authorities.

This was announced in debate on the own affairs health vote by National Health and Welfare Minister Dr Rina Venter.

"I am of the opinion that we should now rationalise certain services provided by the department and where possible shift the execution of these services to local authorities."

This decision by the Ministers' Council proved its desire to take part in the constructive restructuring of health services in South Africa.

The investigation would be launched in the near future, Dr Venter said.

"This process of rationalisation must improve efficiency in health services." — Sapa.

...tive, Mr Simon Buthelezi. Pic by LEN KUMALO.

Tax-free health services urged

Sowetan 29/4/91

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*

Merge private health care with state — ANC paper

BIDay 2/5/91. (85) (289)

TIM COHEN

THE ANC has suggested that the costs of private medicine be regulated and the sector integrated into an overall national health service providing care for the whole population.

A health policy document published for discussion at the ANC's mid-year conference criticises the private sector for its orientation towards those with the means to pay.

"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 care for about 20% of the population. Public funds are used for the training of health workers who later on drift to the private sector."

The document, titled "Towards Developing a Health Policy", says 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. In the longer term, most health care should be provided by the public health service."

The document states that health is a basic human right, and calls for free essential health care to be entrenched in a bill of rights.

It also calls for the preferential allocation of resources to promote health care for the most vulnerable sectors of the community.

"This should apply particularly to those who have suffered psychological and physical trauma because of apartheid."

The public service should be made "accountable" and it would be necessary to attract into the public sector many of those health workers who had chosen private practice.

The document also criticises the duplication of health services in "own affairs" administrations, and calls for more expenditure.

"The government's policy of privatisation and cuts in government spending on health has meant that not enough money is spent on public health services."

The national health service should be unified, non-racial, accessible and affordable. It should give priority to those most in need and focus on eradicating or controlling the major diseases.

It lists as major diseases tuberculosis, measles, polio and AIDS, which it says might soon become the largest public health problem in recent history.

The document also proposes a national medicines policy, stating that too much money is spent on medicines and that there are many sectors of the public health service in which there are not enough medicines in store.

Cast meeting on rift over chamber

BIDay 2/5/91 (129)

WILSON ZWANE

CIVICS Association of Southern Transvaal (Cast) president Moses Mayekiso has acknowledged a serious rift between it and the Soweto People's Delegation (SPD) over the newly constituted Witwatersrand Metropolitan Chamber.

Mayekiso said in an interview Cast would meet today for discussions on the widening rift.

Cast has rejected the chamber, saying it undermined national political demands such as an interim government and a constituent assembly and included "discredited and illegitimate" black councillors.

But the SPD and the Soweto Civic Association (SCA) have welcomed the chamber as a useful forum in which local government issues could be negotiated.

"It is true that some of our members are against the chamber while others have signed its constitution. But I cannot say that the issue of whether to participate in the chamber has divided our membership," Mayekiso said.

Grievances

Top ANC leaders are believed to be involved in efforts to steer the two organisations towards resolving their disagreement over the chamber.

However, Cast had problems with its assistant general secretary Cas Coovadia, Mayekiso conceded.

Coovadia stands accused of speaking to the Press without a mandate from Cast.

"Cas is not our publicity secretary and he has not been mandated to speak as our spokesman," Mayekiso said.

Coovadia confirmed that Cast had sent him a letter outlining its grievances two weeks ago. "But I don't want to enter into a public debate on the matter until I have had the opportunity of consulting with my comrades in Cast," he said.

Mayekiso confirmed that Cast had financial difficulties. Cast was in debt to a Johannesburg hotel it had used as a venue for a number of meetings, he said. He would not disclose the amount of the debt.

"Sam Ntuli (Cast general secretary) has been in Sweden in recent weeks on a fundraising mission. But who does not raise funds? The ANC, Numsa, the Alexandra Civic Organisation and many other organisations go overseas to canvass funds," Mayekiso said.

Health care must be free — ANC

Sowetan 3/5/91

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'

A health policy in a democratic South Africa would be guided by the following goals:

* Promotion of good health which involved social and economic development, adequate living conditions and good working conditions;

* The creation of a single comprehensive national health service

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'

BIDay 22/5/91

JONATHON REES

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. (92)

"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 (85) 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%.

Blind wait years for vital operations

Star 6/5/91

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."

POLITICS

Responsiblity for health services to be on three levels

BDay 14/5/91.

BILLY PADDOCK

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.

New health system totally nonracial

(85) Star 14/5/91

Sweeping changes to health system . . . says Minister of National Health and Population Development Dr Rina Venter.

By Peter Fabricius
Political Correspondent

South Africa's health system is to undergo major restructuring, with the provincial administrations losing contheir control of the country's seven top academic hospitals and local authorities getting full control of primary health care.

Minister of National Health and Population Development Dr Rina Venter announced the rationalisation of the system in Parliament yesterday at the start of the debate on her budget.

She said it would be an entirely nonracial system and that many of the functions of the country's top hospitals would be rationalised to cut costs.

Implementation of the new system would begin as soon as investigations were complete.

Substantial progress could be made within two years but comprehensive changes would probably take as long as 10 years to implement fully.

Dr Venter said health functions would in future be provided at the level of government where they would be most effective.

One of the most important thrusts of the changes was to improve primary health care. Where the three own affairs

Parliament

1991

health departments, the provincial administrations and the local authorities were at present involved in primary health care, this would in future devolve entirely on the local authority.

Dr Venter said local authorities would be given budgets from her department and these would be supplemented by funds from the sale of strategic reserves, such as oil.

Their new responsibilities would include running communal hospitals, she said.

Provincial administrations would probably feel the effects of the changes the most.

They would lose control of the major academic hospitals, which will fall under the Department of National Health — but would be given much greater autonomy.

They would each be controlled by a manager and supervisory council in which the community, the university and the health authorities would be involved.

However, Dr Venter warned that many of the services of these hospitals would be rationalised to avoid duplication.

She promised that the changes would not lead to a deterioration of standards at academic hospitals. In fact, one of the main aims was to maintain those hospitals as "institutions of excellence" by relieving them of some of their burden of providing primary and secondary health care.

The provincial administrations would continue to be responsible for regional health care and hospitals, and would draft and implement a health plan for each of the nine development regions.

A national policy advice committee — representing medical universities, the SA Medical and Dental Council, the nursing council and the health care authorities — would be formed to advise the Minister of Health on matters such as policy, allocation of funds and the rationalisation of highly specialised medical units.

The budget for all levels of health care would be determined nationally but calculated separately.

The manager and supervisory council of each academic hospital complex would decide how to spend the allocated budget.

Dr Venter said academic hospitals would be able to raise their own funds and an investigation into the possibility of allowing doctors at these hospitals to supplement their incomes with private practice would be completed within three months.

Health changes

Political Correspondent

THE South African health system is to be restructured on a non-racial basis.

The provincial administrations will lose control of the country's seven top academic hospitals and local authorities will be given full control of primary health care.

The change was in tandem with the phased dismantling of statutory apartheid, the Minister of National Health and Population Development, Dr Rina Venter, said in Parliament yesterday.

Venter also said many of the functions of the country's top hospitals would have to be rationalised to cut costs. Implementing the new system would begin as soon as investigations were complete.

Medical VAT stays 'with Masa support'

BIDAY 15/5/91

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.

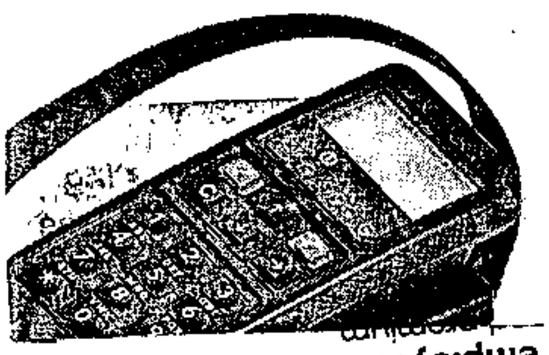
In its representations, Masa said if fees were to be exempt from VAT practitioners would not be entitled to a credit for the input tax they would pay and would thus have to absorb the extra costs.

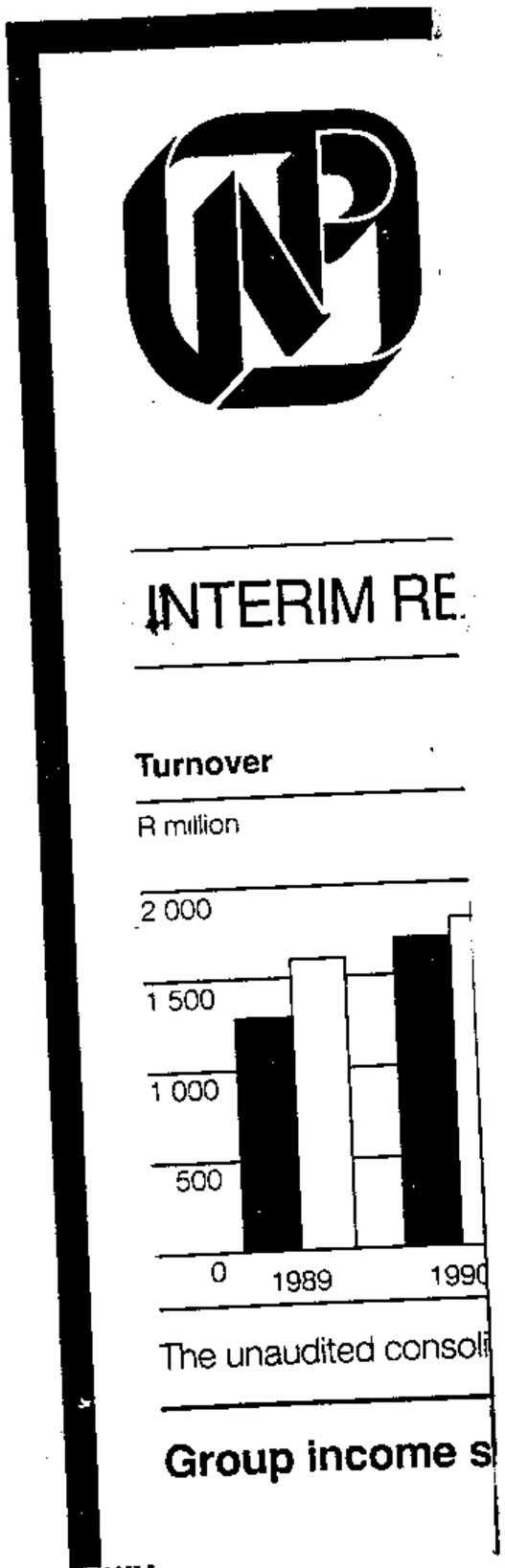
The credit would apply in the case of zero rating or standard rating.

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.





Health sector changes seen as shot in the arm

(85)

Star 15/5/91

By Carina le Grange and Shareen Singh

Health care experts and spokesmen yesterday welcomed the sweeping changes to the health care system announced by Minister of Health and Population Development Dr Rina Venter.

However, while decentralisation was almost uniformly welcomed, other rationalisations were criticised.

Provincial administrations, which would feel the effects of the changes most, according to the Minister, were still studying the full text prior to comment.

CP spokesman Dr Willie Snyman applauded the new independence that academic institutions would enjoy as well as the limited private practice for academic doctors, but he said the downwards devolution of management of primary health care raised the problem of finance.

"Real problems — such as inadequate facilities at academic hospitals, salaries and conditions of health workers and the high cost of medicine — were not addressed. Neither was the matter of value added tax which would put health care out of the reach of many people," Dr Snyman said.

DP spokesman on health Mike Ellis said the new announcements were "very encouraging" but finance would continue to be a major obstacle.

"The Government must be prepared to acknowledge health as a priority backed up by finance, or even allowing a State lottery," he said.

The dean of the University of the Witwatersrand medical school, Professor John Milne, also fully supported the autonomy of academic hospitals and their freedom to raise funds. He would favour a form of equal partnership with regional health authorities, and the running of services on a joint, but equal, basis.

On the issue of hospital doctors having limited private practice, Professor Milne said the ideal would be for these doctors to be paid better so that they would need to go into private practice.

Medunsa medical dean Professor T Heyl was delighted that management autonomy would be granted to medical schools. This would lead to more efficient financial administration and spending of public funds, he said.

Senior lecturer and physician Dr Yussuf Veriava, of Wits and the Coronation Hospital, welcomed the new autonomy but expressed concern regarding the autonomy of academic institutions.

He said that if academic institutions became totally autonomous, they might not link up with other levels of health care as it was the "duty" of academic hospitals to contribute to the upgrading of services at other hospitals.

Dr Veriava criticised Dr Venter's exclusion of certain widely representative health organisations on the national policy advisory committee.

"To have the Medical Association of South Africa on the committee and leave out organisations that have greater grassroots contact is a major shortcoming."

A spokesman for the National Medical and Dental Association, Dr Fazel Randera, like Dr Veriava, felt Dr Venter's exclusion of "progressive health-sector organisations" from the national policy advice committee could lead to problems.

He further said that in view of the "acute crisis" experienced by academic hospitals, new autonomy measures may lead to the richer and more urban medical schools continuing to be dominant.

Dr Veriava also said that raising funds would put some academic hospitals — such as Medunsa — in less affluent areas at a disadvantage compared with their Wits counterparts.

Keep 1st world medicine — MRC

85

CT 15/5/91

Staff Reporter

FIRST World medicine had to be maintained in South Africa to solve Third World health problems, speakers at the tabling of the Medical Research Council 1990 annual report said last night.

In his presidential address, MRC president Dr Philip van Heerden said Africa's history had shown that "the health problems of the Third World cannot be solved" without highly qualified medical staff.

He said it was essential to maintain high standards, or South Africa would be dependent on others to solve its problems.

"Research personnel should have every opportunity to undertake quality research at academic institutions.

Where necessary, pilot action programmes should be launched to entice SA researchers back into the country, Dr Van Heerden said.

The MRC group executive for clinical and experimental research, Dr Roger Stewart, highlighted the need for First World medicine to cure Third World problems.

He said a procedure developed by the MRC/UCT Ischaemic Heart Disease Research Unit induced cardiac arrest so that open-heart surgery could be performed.

Dr Stewart said research was at present being carried out during surgery on ischaemic heart disease, a First World illness, and on patient's with faulty heart valves due to rheumatic fever, a Third World disease.

Fm 17/5/91 (85)

HEALTH Fm 17/5/91 (85)

GETTING BETTER

Health Minister Rina Venter concedes that government faces an uphill battle in rehabilitating SA's crumbling public health services, but at least she's made a start.

The restructuring of health services she announced this week will streamline administration and — it is hoped — ensure the more effective use of limited financial resources.

On paper the plan is perhaps the boldest step government has taken so far to prepare the health services for the new SA. It cuts across current racial and ideological divisions by providing the framework for:

☐ Nonracial "democratic" control of primary health care at local government level;

☐ Control by the provinces of regional hospitals organised on the basis of the country's nine development regions which include the non-independent homelands; and

☐ Administrative autonomy for the seven academic hospital complexes, comprising 13 hospitals in all.

Own affairs health services, effectively brushed aside when hospitals were opened to all last year, continue to exist in statute only. Venter argues that legislation would be needed to scrap the own affairs departments, and besides, she says, own affairs are currently allocated only 8% of total health spending.

In that case government critics may well ask why it's necessary to continue paying two own affairs Ministers — Chris April in the House of Representatives and Baldeo Dookie in the House of Delegates — R187 000 a year each plus official residences and motor cars, and the infrastructure to keep their offices running, when they're clearly redundant.

Democratic Party's Colin Eglin showed earlier this month that government can in fact take administrative steps to effectively dismantle the own affairs system without having to amend the constitution.

Venter, however, is understandably more concerned with implementing the new strategy than debating the merits of own affairs. The plan provides for national health policy to be determined by government in consultation with organisations involved in health services.

Academic hospitals — previously under provincial control — will become autonomous, each under a manager and supervisory council. Funds allocated by the State will be controlled by the council.

Provincial authorities will continue to control regional hospitals. Management autonomy is envisaged in the longer term, says Venter.

She has also ordered an investigation, the results of which she wants within three months, into the feasibility of doctors at State hospitals supplementing their salaries through limited private practice.

Primary health care, currently controlled and administered by six different authorities — the three own affairs departments, the provinces, local authorities and the national Health Department — will be taken over by local authorities.

Where necessary the provinces will assist with phasing in local control, and in areas where local authority administration of primary health care is impossible — such as some black townships where most administration has effectively collapsed — the provincial authorities will render the service while simultaneously working towards the re-establishment of local authority control.

Venter says the "democratisation" of health services will increasingly involve local communities in the planning and development of their own services.

The State will help fund primary health care on a formula currently being developed. Some of the money that will become available through the reduction of strategic stockpiles will be allocated to primary health care services. ■

Venter ... *a healthy start*

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.

Province and Accommodation

Name of children's home	Cape	Transvaal	OFS	Natal
Othandweni Family Care Centre		88		
Bethany Girl's Home		160		
Legae la Rona		200		
Tshirelesong			85	
Othandweni Infant's Home				120
St Vincent				110
Ekujabuleni				32
Sacred Heart				170
Indian				
Lakehaven				80
Sunlit Gardens				60
M.A. Motala				30
Aryan Benevolent Home				102
Muslim Darul Yatama Wal Masakeen				66
Boys Town, Genazzana (Tongaat)				55
Boys Town, Verulam				10
Coloured				
Annie Starck Village	60			
Boys Town Duin-en-Dal	60			
Bruce Duncan Kinderhuis	70			
Christine Revell Kinderhuis	30			
G C Williams Kinderhuis	60			
Habibia Children's Home	18			
Heatherdale Kinderhuis	60			
Holy Cross Orphanage	115			
James House	12			
Leliebloem House	60			
Margaret's House	10			
Moria Kinderhuis	20			
NG Sending, Kamieskroon	100			
NG Sending, Pofadder	132			
Ons Plek	16			
Patrick's House	30			
R K Kamieskroon	74			
St Francis, Athlone	60			
St Francis, Onseepkans	60			
St George's House	40			
St Mary's Kinderhuis	40			
SOS Kinderdorp (Port Elizabeth)	80			
Steinthal Kinderhuis	646			
The Homestead	17			
The Retreat	10			
SOS Village Johannesburg		160		
St Joseph's Home		88		
St Nicholas, Newville		60		
Bethshan Children's Home				30
St Monica's Home				84
St Philomena's Orphanage				80

Province and Accommodation

Name of children's home	Cape	Transvaal	OFS	Natal
St Theresa's Home				105
St Thomas's Home				61 and

(d) White : 22/4/91
Black : 30/3/91
Indian : 22/4/91
Coloured : 31/3/91

Social services: money set aside

320. Dr W J BOTHA asked the Minister of National Health:†

(a) What percentage of the money set aside for social services in respect of Whites, Coloureds, Indians and Blacks, respectively, during each of the latest specified two financial years for which figures are available, (i) reached the recipients of social benefits and (ii) was spent on (aa) administrative and (bb) other specified expenses and (b) what amounts are involved?

B834E

The MINISTER OF NATIONAL HEALTH:

	WHITES		COLOUREDS		INDIANS		BLACKS	
	1988/89	1989/90	1988/89	1989/90	1988/89	1989/90	1988/89	1989/90
(a) (i)	95.2%	94.7%	96.06%	98.22%	97.76%	97.06%	95.6%	97.49%
(ii)(aa)	4.8%	5.2%	3.54%	1.78%	0.18%	0.19%	4.4%	2.51%
(bb)	unknown	unknown	unknown	unknown	1.94%	2.31%	unknown	unknown
(b) (i)	R821 375 000	R918 951 000	R6 777 674 000	R813 898 000	R156 032 000	R178 009 000	R999 245 000	R1 186 651 000
(ii)(aa)	R4 142 000	R51 000 000	R24 860 000	R14 720 000	R290 000	R365 000	R7 692 000	R5 294 000
(bb)	unknown	unknown	unknown	unknown	R3 107 000	R4 114 000	unknown	unknown

Above information as received from various departments. Concerning Blacks the information is only applicable to the RSA.

Dr Nelson R Mandela High School: statistics

322. Mr J VAN ECK asked the Minister of Education and Training:

With reference to the Dr Nelson R Mandela High School in Crossroads as at 8 April 1991, (a) what was the (i) total pupil enrolment and (ii) capacity of the school, (b)(i) what were the names of the textbooks required for each standard, (ii) how many copies of each were required and (iii) what is the total cost of acquiring these books, (c)(i) what science equipment was available in each of the four laboratories at this school, (ii) what (aa) equipment and (bb) furniture was required and (iii) what is the cost of providing these items of (aa) equipment and (bb) furniture and (d)(i) how many books were available in the school library, (ii) how many books needed to be acquired and (iii) what is the cost of providing these books?

B840E

The MINISTER OF EDUCATION AND TRAINING:

(a) (i) 1 865 pupils
(ii) 1 225 pupils

(b) (i) (ii)

Titles of Hand Books	Number of copies
Std. 6	
Akasia Taalreeks	50
Active General Science	150
Active Mathematics	100
Active Geography	200
Active History	100
A Book of English	250
Joey	80
African Skyblue	250
Active Business Economics	75

Improve primary health services

(85) CT 20/5/91

By DEREK YACH and YASMIN VON SCHIRNDING

SOUTH AFRICA will experience rapid urbanisation for several decades as a result of the removal of restrictive legislation and deteriorating conditions in rural areas.

Urbanisation in developing countries has been largely unplanned and uncontrolled, resulting in deteriorating health conditions in growing peri-urban slums. Nevertheless, urban residents have greater potential for upward social mobility than their rural counterparts owing to better access to jobs, education and health services.

In 1987 the South African Department of National Health and Population Development requested the Medical Research Council to assess the impact of urbanisation on health and to identify means of reducing adverse effects. Below are selected results from a wide range of research projects undertaken nation-wide over the last three years.

Council researchers have focused on certain ill-health conditions which are directly related to poverty (measles, diarrhoea and malnutrition); environmental pollution and the physical environment (lead poisoning in inner cities, respiratory problems in children); to consumer patterns (particularly smoking); as well as social and political instability (trauma, particularly interpersonal violence).

Measles — Studies on measles prevention consistently point to a need for integration of curative and preventive health service. New arrivals in the city have much poorer vaccination coverage than long-term residents and even intensive vaccination campaigns failed to achieve adequate protection.

There is an urgent need for targeted intervention among specific risk groups, such as new arrivals and children born at home.

Healthy lifestyle

Coronary heart disease — The first study of risk factors for coronary heart disease in the South African black population has shown that there is still time to prevent an epidemic of ischaemic heart disease and coronary heart disease in urban blacks, but that smoking rates in men and hypertension need urgent preventive attention.

This finding highlights the need for health promotion efforts in schools to encourage adopting a healthy lifestyle and community health education campaigns to improve awareness of available hypertension screening services. Certain commercial activities (such as tobacco advertising) need to be restrained and new social marketing strategies encouraged for disseminating information on health (as seen in a recent AIDS prevention project).

Diarrhoeal-related diseases — Results from the first national environmental health study of the urban coloured population of South Africa have revealed that a significant proportion of people do not have access to amenities such as reticulated water or flush toilets.

Both these factors were found to be associated with high diarrhoea rates in young children. Limited information exists for the black population, although results from a sample of black people in the Cape Peninsula indicate that only around 50% of people live in formal housing, with the rest living in shacks or tents. A similar percentage have access to reticulated water inside their homes.

In the unplanned informal (or squatter) areas the virtual total lack of sanitation facilities and solid waste disposal services and the scarcity of pure water is a matter of grave concern.

Environmental pollution — Peri-urban settlements in South Africa (already vulnerable with respect to their risks for nutritional and infectious diseases) are subject to additional environmental health hazards of both rapid urbanisation and industrialisation. Thus they may be more exposed to dust, chemical pollution (both from nearby industry and domestic cooking and heating), and noise.

'Inner-city decay'

Research by the council has shown that mortality rates for respiratory illness among coloured infants are significantly higher than those for whites; in some urban areas (where rates are generally higher than in rural areas) there is evidence that respiratory illness is becoming an even more important cause of death than diarrhoea.

Inner-city decay — A further environmental problem relating to the urban environment concerns "inner-city decay". Infants and young children in inner cities may in some circumstances be particularly susceptible to ill-health and disease due to their inherent vulnerability, impoverished living conditions and lack of parental supervision and recreational facilities.

Psycho-social stress — Cooper from UCT Community Health describes the women of Khayelitsha as experiencing "quadruple oppression ... on the basis of race, social class, gender and as new arrivals in an urban environment".

Gillis (Psychiatry, UCT) confirmed this and showed very high prevalences of psychological stress and depression, particularly in elderly women, in new arrivals to the city compared with those in a more established suburb. Stress and depression are probably risk factors contributing to the high rates of traumatic injury resulting from interpersonal violence (half of all trauma cases seen in hospitals) reported in the study of trauma in Johannesburg and Soweto.

Need for intersectoral co-ordination — The key to sustained urban health improvement is firstly, long-term planning involving various sectors relating to housing, health, environmental protection, transportation, planning and education.

In addition, community mobilisation and participation provide the most important human dimension to the success of living in the urban environment. Communities can become involved in innovative urban community health worker programmes as seen in the SACLA project underway in Khayelitsha.

There is also an obvious need to improve access to primary health care, integrate existing preventive and curative services and develop new models of urban primary health care.

☐ *Derek Yach and Yasmin von Schirnding wrote this report on behalf of the staff of the Medical Research Council.*

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.

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.

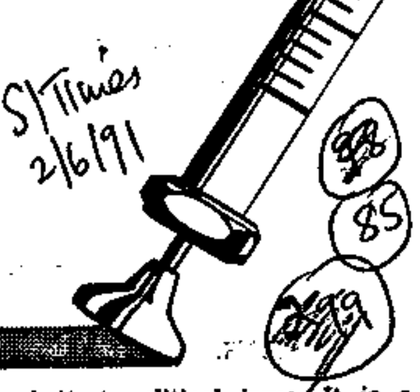
Emergency

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.

Considering the people's health

(85) Star 3/6/91.

The Johannesburg health department is recognised as being one of the most progressive in South Africa and has been acclaimed internationally for its work in Aids education and community service.

Deputy medical officer of health Dr Nicky Padayachee was last week appointed executive director of a new social responsibility department — the health and housing business unit, which includes an urbanisation portfolio.

"Many cities far and wide — in the Soviet Union, Cuba and United States — have asked us to share our experience.

"We are the most progressive health department in the country," said Dr Padayachee.

Johannesburg is at the forefront of a move to decriminalise prostitution.

Underground

"We are not saying we encourage the field of sex workers, but it has been with us for a very long time and will probably still be here after I am gone. It is very difficult to work with individuals and impact on their lives if people are prosecuted and go underground."

Worrying Dr Padayachee is the fact that 60 percent of all reported Aids cases in the country occur in Johannesburg.

"Aids is one of the most serious threats facing the future of this country."

Dr Padayachee is a specialist in community health, and lectures at the University of the Witwatersrand.

He is likely to become MOH of Johannesburg when Professor Hilliard Hurwitz retires.

He believes health is a total state of well-being: proper housing, a good job and a stable family life.

"The department is aimed at combining health, housing and urbanisation in the proper perspective of total human development.

"People in informal settlements know more about their lives than anyone else. We must go to the community and ask them what their health problems are, what they use, what they need.

"It is a long-term approach at solving problems. We are not abandoning immediate care, but we can't keep on treating a child with asthma who is living in a one-room shack with poor ventilation. One must treate the cause to solve the problem."

Dr Padayachee said creative, innovative solutions were needed to address the housing backlog.

"The biggest challenge for cities will be people moving in. Many are poor and disadvantaged. They end up on the fringe of cities and in slums in informal housing. With a deterioration in living standards, health problems occur.

"We have to concentrate on the people who are the most disadvantaged."

Dr Padayachee refused to have his numerous awards listed and said he was merely furthering the work of people such as his mentor, Professor Hurwitz.

● For a future Jo'burg — Page 11

A letter from Mr Dhlakama to Mr Blanchard in November 1986 de-

Mendes Arnaut, who ... pear in court. — Sapa.

SA medical profession 'damaged' by Biko affair

By VIVIEN HORLER
Medical Reporter

THE editor of the South African Medical Journal has spoken out about the controversial role of the medical profession in the death of Black Consciousness leader Steve Biko in 1977.

Dr Nic Lee wrote in an editorial this week: "Neither the Medical Association of SA, nor the Medical Journal emerged with any great credit from the episode.

"Although the memory of the events surrounding Steve Biko's death in detention may have become blurred with time, the damage they did to the credibility and reputation of the medical profession in South Africa — both nationally and internationally — is still not far from the surface of consciousness for many people."

The controversy in the medical profession resulted in a flurry of resignations from the Medical Association and a split between Masa and the newly formed National Medical and Dental Association (Namda).

Masa members regarded Namda as a radical political group and Namda saw Masa as reactionary and conservative.

Letters sent to the Medical Journal were not published.

Wrote Dr Lee: "Worst of all from the point of view of the Medical Journal was an unsigned editorial which argued that the SA Medical and Dental Council should not be criticised for its handling of the affair because it had been helpful when Masa had negotiated a new medical scheme tariff structure with the Minister of Health.

"A more unfortunate comparison would have been hard to make."

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.

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.

War almost won, says Masa

(85) CT 17/6/91

Own Correspondent

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According to the Association of Fulltime Specialists of Wits University, 60% of specialists at the Baragwanath, Coronation and Johannesburg General hospitals were considering resigning because of inadequate remuneration packages.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Allocation of land/houses: responsibility

*1. Mr K PANDAY asked the Minister of Planning, Provincial Affairs and National Housing:

(1) Whether his Department will be responsible for administering the allocation of land and/or houses after the repeal of the Group Areas Act, No 36 of 1966; if not, which Government Department will be charged with this responsibility; if so, to what extent;

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

D198E

The DEPUTY MINISTER OF PLANNING (for the Minister of Planning Provincial Affairs and National Housing):

(1) The present constitutional arrangements in this regard remain unchanged.

(2) In terms of Item 5 of schedule 1 of the Republic of South Africa Constitution Act, 1983, community development i.e. housing and the development of land, is regarded as an own affair and the various own affairs departments will continue to administer it. The functions of the Department of Planning, Provincial Affairs and National Housing provincial administrations and the Department of Development Aid in respect of housing and the development of land, will likewise be maintained pending the rationalising of functions and deliberations with a view to a new constitutional dispensation.

VAT: service charges on municipal houses

*2. Mr K PANDAY asked the Minister of Finance:

(1) Who will be responsible, once value-added tax has been introduced, for paying service charges on municipal houses in cases where prices of houses have not been finalised because of delays by the Minister of Housing or municipality concerned;

(2) whether he will make a statement on the proceudre that will be followed in this regard?

D199E

The MINISTER OF FINANCE:

(1) Rental of dwellings used for accommodation of a natural person is exempt from value-added tax and municipal rates are not subject to the tax. The supply of services such as water, electricity, gas, sewerage and refuse removal is, however, subject to the tax. The person responsible for the payment of the tax to the State is the person supplying such services. He will normally recover the tax from the person to whom he supplies the goods or services in the consideration he charges for the services.

(2) No. The procedure to be followed depends on the contractual relationship between the supplier of the service and the person to whom the service is rendered.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, arising out of the hon the Minister's reply, is it not correct that he once stated in the Chamber of Parliament that even he does not clearly understand the VAT details? [Interjections.]

The MINISTER OF FINANCE: Sir, if the hon the Leader of the Official Opposition did not see my tongue in my cheek, it is not my problem! [Interjections.] I would gladly have myself subjected to cross-questioning in any circle. However, I must add that if it were expected of me to become so *au fait* with taxes at the lowest accounting level, I would seek other employment, because then I would act as a consultant, and it would not be necessary for me to work at my present salary! [Interjections.]

Control of medicines: stock/agricultural remedies

*3. Mr N JUMUNA asked the Minister of National Health:

(1) Whether she intends to extend the control exercised over human and veterinary medicines in terms of the provisions of the Medicines and Related Substances Control Act, No 101 of 1965, to include stock remedies and agricultural remedies presently controlled in terms of the provisions of the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies Act, No 36 of 1947; if not, why not; if so, (a) why and (b) what are the relevant details;

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

D203E

The MINISTER OF NATIONAL HEALTH:

(1) No, there is clear differentiation between a stock remedy and an agricultural remedy on the one side and a veterinary medicine on the other side, according to the respective Acts. They exclude each other;

(2) no.

Mr N JUMUNA: Mr Chairman, arising out of the hon the Minister's reply, will she agree that the deletion of the reference to Act 36 of 1947 from Schedule 1 to the Medicines and Related Substances Control Bill, will extend control of Act 101 of 1965 to include stock remedies and agricultural remedies? I have the deletion from Schedule 1 here with me.

The MINISTER OF NATIONAL HEALTH: Mr Chairman, I shall have a look at the explanation put to me by the hon member. However, I stand by the explanation provided by my technicians, namely that one excludes the other.

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

Own Affairs:

Second access road in Chatsworth: procedure

1. The LEADER OF THE OFFICIAL OPPOSITION asked the Minister of Housing:

(1) Whether he intends following the same procedure in regard to the second access road in Chatsworth as he did in regard to providing the Chatsworth/Shallcross link road; if not, why not;

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

D215E.INT

The MINISTER OF HOUSING: Mr Chairman, the answer is no. The provision of this road is the responsibility of the Durban City Council which mooted the road as an essential requirement when the plans for the development of Chatsworth were formulated.

The answer to the second part of the question is no.

The LEADER OF THE OFFICIAL OPPOSITION: Mr Chairman, I am surprised that the hon the Minister now says that matter is the responsibility of the Durban City Council. This interpellation is linked to the Shallcross link road which, by virtue of the statement made by the hon the Deputy Minister on 23 May 1991 in this House at the request of the hon the Minister of Housing, is also the responsibility of local government bodies, one of which is the Durban City Council. That is why a loan arrangement was being negotiated.

If, however, one were to put the Shallcross link road and the Chatsworth second access road on a scale, the importance of the Chatsworth second access road would far outweigh that of the Shallcross link road. What we want to know is why there are differences in approach. Why are there double standards? According to the last submission made by the hon the Minister of Housing at the housing advisory committee meeting held in Durban, there is a new designed road. Consequently the question of the new designed road cutting across the Stainbank Nature Reserve is no longer an obstacle.

I think this House and the community deserve an explanation in that the Chatsworth second access road is a direct link to Chatsworth which is a resettlement housing scheme in respect of which the Durban City Council is only the agent of the State. Therefore, one has to consider, on the one hand, a small population which is benefiting and on the other, the welfare and the benefit of approximately a quarter of a million of South Africa's people.

I find it strange and unacceptable that the Department of Housing has not undertaken to appoint consultants to go on tender in order to award contracts in respect of the Chatsworth second access road where we accept that the

VAT ruling 'not final'

B/Day 19/6/91.

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.

Outdated laws 'keep health costs rising'

CT 20/6/91

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.

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.

manship of Judge Goldstone arbitrated during February 1990 that he was responsible for his own death.

SABC: rate for M-Net broadcasts

377. Mr L F STOFBERG asked the Minister of Home Affairs:†

Whether the SABC undertakes the broadcasting of M-Net programmes; if so, what is the average cost per minute of broadcasting time paid to the SABC by M-Net for this service?

B970E

The MINISTER OF HOME AFFAIRS:

The SABC does not undertake the broadcasting of M-Net programmes but has a transmission agreement with M-Net for the distribution of the M-Net broadcasting signal. According to this M-Net rents the channel on a 24 hour basis irrespective whether the full 24 hours are used. The rental fee is calculated on the full cost of the usage of the existing infrastructure, including rental, plus a profit margin. There is no government involvement in the mutual bargaining of tariffs of this nature.

Diamond and Gold unit: budgeted cost

386. Adv M J MENTZ asked the Minister of Law and Order:†

(1) What was the budgeted cost of the Diamond and Gold Unit in each of the latest specified five financial years for which information is available;

(2) whether there are any reasons why, in the framework of the free market policy of the Government, this unit should continue to exist at the expense of the taxpayer; if so, what reasons;

(3) whether, in the light of the abovementioned framework, consideration is being given to assigning control of the smuggling of gold and diamonds from mines to the mine companies concerned; if not, why not; if so, what measures he envisages to secure the taxpayer against the costs involved in controlling the smuggling of gold and diamonds from mines?

B1018E

The MINISTER OF LAW AND ORDER:

(1) The Diamond and Gold Unit, as a specialized unit of the Division: Crime Combating and Investigation, forms an integral part of the South African Police. The costs involved in the functioning of this unit are financed out of the global budget of the Police and is not accounted and recorded separately. It is therefore not possible to furnish the bedgeted costs.

(2) Yes, shortly after the discovery of uncut diamonds and other raw precious metals in South Africa, and the realization by the Government at that time, of the foreign exchange value which these products held for South Africa's economic prosperity, these products were controlled by legislation. These products still play a very important role in the economic progress of the Republic, which at the same time ensures a great measure of prosperity for all the inhabitants of South Africa.

It thus follows that these products must not come into circulation in the free market, since it would have an extremely negative influence on the economy of South Africa, which would also flow over to the tax-payers pocket. Legislation is thus still necessary to control the possession and dealing in thse products and a transgression thereof naturally constitutes an offence.

The functions of the South African Police, which also includes the Diamond and Gold Unit, is, inter alia, the following:

— the investigation of any offence or alleged offence; and

— the prevention of crime.

The illegal possession and dealing in these products thus falls within the ambit of the functions of the South African Police, and the Police will still continue to fulfil their responsibilities in this regard.

(3) The smuggling of raw precious metals and uncut diamonds from mining premises is still being controlled by security officials in the service of the mining companies involved. As soon as arrests are carried out by these officials, the suspect(s) and any exhibits, are handed over to the Diamond and Gold Unit, who are responsible for the pursuance of judicial proceedings, for further investigation which

may result therefrom. No change of this procedure is envisaged.

Squatters near Ventersdorp: attacks by farmers

390. Mr D H M GIBSON asked the Minister of Law and Order:

(1) Whether any incidents involving attacks by farmers on squatters near Ventersdorp were reported on or about 11 May 1991; if so, what were the circumstances surrounding these incidents;

(2) whether any squatters were injured during these incidents; if so, how many;

(3) whether any farmers have been (a) arrested and (b) charged in connection with these incidents; if not, why not; if so, (i) how many in each case and (ii) what is the nature of the charges;

(4) whether any property was damaged during these incidents; if so, what was the value of the property damaged?

B1030E

The MINISTER OF LAW AND ORDER:

(1) As the furnishing of any answer to the question will be in anticipation of the outcome of the investigation and judicial action which may result therefrom, it would be inapt to react thereto at this stage, except to say that the South African Police view the events at Goedgevonden on the date in question in a very serious light.

I, therefore, kindly request the hon member to abide by this, so that the judicial process can take its course.

This matter is being investigated thoroughly and as a matter of urgency.

(2) Yes, in Goedgevonden 7 persons were seriously injured and in Tshing 25.

(3) (a) and (b) Yes.

At this stage three white males have been arrested and charged with public violence at the Goedgevonden squatter camp. As regards the events at the Tshing Black Residential Area no arrests have as yet been made.

(4) Yes, the provisional estimate is that the damage in Goedgevonden amounts to R1 700,00 in respect of 4 structures, and amounts to R5 000,00 in Tshing in respect of 5 structures.

Note:

I wish to refer the hon member to column 8685 to 8700 and column 8701 to 8712 in Hansard when the matter was discussed in the House of Assembly and House of Representatives, respectively on 14 May 1991.

I am content with what I said and the points of view I took during the two debates.

Minister/chief executive directors: lawsuits/pay-outs

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

(1) Whether any lawsuits were brought against (a) her in her capacity as Minister of National Health and/or (b) any specified chief executive director of provincial hospital services in 1990; if so, what (i) were the circumstances of each lawsuit and (ii) was the outcome in each case;

(2) whether (a) she and/or (b) any specified chief executive director of provincial hospital services paid out any money in 1990 (i) as a result of successful lawsuits brought against them and (ii) in out-of-court settlements; if so, what amount in respect of each case?

B1093E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Yes,

(i) 1. Application for the setting aside of the prohibition of the use of hydroquinone in cosmetics.

2. Application for an order declaring that the Administrator of the Cape's proposed scheme concerning the repackaging and distribution of medicines be declared illegal.

3. Damages for death due to incorrect preventative treatment for malaria and

(ii) 1. The application was dismissed with costs.

2. The court held that the Cape Provincial Administration contravened the Medicines and Related Substances Control Act, 1965.

3. Case pending.

Executive Director of Provincial Hospital Services

Cape Provincial Administration

(1) (b) yes,

(i) 1. stillborn baby.

2. Swab left in patient.

3. Loss of hearing due to prolonged use of medication.

4. Transplanted organs allegedly too "large" for heart/lung transplantation patient.

5. Psychiatric patient allegedly detained in hospital unlawfully.

6. Death of private patient due to alleged negligence of private doctors.

7. Patient sterilised without permission.

8. Permanent damage to muscles of limbs after alleged delay in execution of operation.

9. Death of patient after surgery due to alleged negligent monitoring of patient's post-operative recovery.

10. Swab left in patient.

11. Stillborn baby.

12. Baby's arm injured at birth.

13. Patient granted written permission for sterilisation, but denied it later.

14. Vaginal swab left in patient.

15. Death of baby after Caesarean section due to alleged delay thereof.

16. Baby's one arm paralysed and the other broken at birth.

17. Patient with severe burn wounds died while receiving anaesthetic.

18. Patient became blind after operation.

19. Stillborn baby.

20. Death of patient fifteen months after leg operation.

21. Stillborn baby.

22. Back injuries due to fall from theatre trolley.

23. Patient sustained burn wounds due to instruments which were too hot.

24. Death of terminal private cancer patient after stomach operation.

25. Patient with fractured leg discharged from hospital.

26. Corrugated drain left in patient's pelvis.

27. Swab left in patient's back.

28. Loss of finger.

29. Application for an order declaring that the Administrator of the Cape's proposed scheme concerning the repackaging and distribution of medicines be declared illegal and

(ii) 1. case closed due to lack of further interest by plaintiff's attorney.

2. Case pending.

3. Case closed due to lack of further interest by plaintiff's attorney.

4. Case pending.

5. Case closed due to lack of further interest by plaintiff's attorney.

6-12. Case pending.

13. Case closed due to lack of further interest by plaintiff's attorney.

14. Case closed due to lack of further interest by plaintiff's attorney.

15-28. Case pending.

29. The court held that the Cape Provincial Administration contravened the Medicines and Related Substances Control Act, 1965.

Natal Provincial Administration

(1) (b) yes,

(i) 1. alleged negligent treatment of a leg injury.

2. Patient being transferred by ambulance, sustained injuries necessitating amputation of his middle toe.

3. Abscess due to negligent removal of a drain during a Caesarean section.

4. Patient fell from a window and sustained numerous fractures due to negligent care.

5. Swabs left in patient after delivery.

6. Failed sterilisation.

7. Incorrect epileptic medication given to patient.

8. Failed sterilisation.

9. Mastectomy due to alleged negligence in detecting breast cancer.

10. Failed sterilisation and

(ii) 1-10. case pending.

Provincial Administration of Orange Free State

(1) (b) no,

Transvaal Provincial Administration

(1) (b) yes,

(i) 1. death due to negligent handling of ventilator pipe during operation.

2. Amputation of arm after cut had been stitched in ward.

3. Broken right arm sustained from fall in hospital and

(ii) 1-3. case pending.

(2) (a) *Minister of National Health*

(i) no and

(ii) no.

(b) *Executive Director of Provincial Hospital Services Cape Provincial Administration*

(i) yes,

R10 000,00 plus costs

R19 000,00 plus costs (notice of appeal was given and judgment is being awaited)

Costs (notice of appeal was given and judgment is being awaited) and

(ii) yes,

R30 000,00

R8 500,00

R5 000,00

R20 000,00

R600,00

R10 955,89

Natal Provincial Administration

(i) yes,

R27 812,00 and

(ii) yes,

R2 077,50

R78 960,00

R13 000,00

R19 500,00

R20 000,00

Provincial Administration of the Orange Free State

(i) no and

(ii) yes,

R700,00

Transvaal Provincial Administration

(i) no and

(ii) yes,

R1 723,52

R18 963,00

R3 500,00

R10 000,00

R1 500,00

R1 000,00

R86 692,55

R4 219,16

R2 500,00

R9 000,00

Foster parents: monthly State grants

419. Mr R F HASWELL asked the Minister of National Health:

(a) What are the monthly grants paid by the State to foster parents of children of each race group and (b) in respect of what date is this information furnished?

B1098E

The MINISTER OF NATIONAL HEALTH:

(a) Whites : R212 pm

Indians and Coloureds : R190 pm

Blacks : R160 pm and

(b) 1 April 1991.

Certain person: obstruction of CCB probe

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

(1) Whether he or the South African Police have been informed of a claim by a certain person, whose name has been furnished to the Police for the purpose of the Minister's reply, that he burnt documents and removed weapons to confuse the Harms Commission in its investigation into the activities of the Civil Co-operation Bureau (CCB); if not, why not; if so, what is the name of this person;

(2) whether this claim is being investigated; if not, why not; if so, (a) what progress has been made in this investigation, (b) what have been the findings so far and (c) what efforts are being made to establish the nature of the burnt documents;

(3) whether he or the South African Police have been informed that the above person also claims to have been a member of the South African Police; if not, why not; if so,

(4) whether he will (a) confirm this claim and (b) make a statement on the probability of this person's involvement in CCB activities?

B1100E

The MINISTER OF LAW AND ORDER:

(1) No.

Mr Ronald Bezuidenhout made the allegation to the Vrye Weekblad with regard to the removal of weapons and the burning of documents.

(2) Yes.

(a) Mr Bezuidenhout was questioned about the allegation. He confirmed the allegation but indicated that he does not know what the contents of the documents were, but is of the opinion that it was documents which dealt with the normal activities at Vlakplaas. He denies that he helped with or was aware of the transport of Russian weapons.

(b) and (c)

No confirmed or final finding has been made to date. It is so, however, that correspondence is destroyed from time to time in strict accordance with instructions embodied in the Archives Act, 1962 (Act 6 of 1962). Although it cannot be confirmed, the burning of documents to which Mr Bezuidenhout referred, could possibly have occurred in terms of these instructions.

No further information which proves the contrary, or that the documents were in

any way involved in the activities of the Harms Commission, could be found to date.

No substantial evidence could be found that weapons were removed.

(3) Yes.

(4) (a) No, because Ronald Bezuidenhout was never a member of the South African Police.

(b) No.

***Per capita* expenditure**

421. Mr J H MOMBERG asked the Minister of Education and Training:

(1) What was his Department's *per capita* expenditure on education for the Republic during the latest specified 12-month period for which figures are available;

(2) whether his Department has statistics on the *per capita* expenditure on education for the (a) Qwaqwa and (b) KwaZulu Department of Education and Culture; if not, why not; if so, (i) what are the relevant statistics and (ii) in respect of what period is this information furnished?

B1104E

The MINISTER OF EDUCATION AND TRAINING:

(1) R1 194 (for the Department of Education and Training only).

(2) (a) and (b) No. The Department of Education and Training does not have the relevant information officially at its disposal.

Sebokeng: shooting incident at beerhall

429. Mr D H M GIBSON asked the Minister of Law and Order:

(1) Whether he or the South African Police have been informed of an incident in which a number of persons were killed and injured when gunmen allegedly opened fire in a beerhall in Sebokeng; if so, (a) what were the circumstances surrounding the incident and (b) how many persons were (i) killed and (ii) injured;

(2) whether this incident is being investigated; if not, why not; if so, what progress has been made;

(3) whether any arrests have been made in connection with the incident; if so, (a) how many, (b) what are the names of those arrested and (c) what is the nature of the charges laid against them?

B1122E

The MINISTER OF LAW AND ORDER:

(1) Yes.

(a) On 23 May 1991 at 19:10 2 male persons who were allegedly armed with AK47 rifles, entered the Co-operation beerhall in Zone 14, Sebokeng and without any reason started firing at those present.

(b) (i) 8 People

(ii) 23 People.

(2) Yes, charges of murder and attempted murder are being investigated. All the information which has so far come to the attention of the Police has received attention, but without success. The injured can also not supply any information on the matter, or identify the suspects. All possible steps are being taken to trace the accused and I make an urgent appeal to any person who disposes over any information regarding the incident, to contact the South African Police.

A reward of R40 000,00 is being offered for any information which will lead to the arrest and conviction of the accused.

(3) No.

(a) to (c) Fall away.

Vote No 24: Main Division 5

439. Mr W J D VAN WYK asked the Minister of Public Works and Land Affairs:†

Whether with regard to Vote No 24—Public Works and Land Affairs, he will subdivide the amount of R1 416 239 000 under Main Division 5—"Provision of buildings, structures and equipment", according to aims; if not, why not; if so, what are the relevant details?

B1145E

The MINISTER OF PUBLIC WORKS AND LAND AFFAIRS:

Yes. One of the primary aims of the Department of Public Works and Land Affairs is the

— 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 abovementioned 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.

Drastic cutbacks hit blood service

VIVIEN HORLER

Medical Reporter

DRASTIC cutbacks loom for the Western Province Blood Transfusion Service as slashed hospital funding and a worldwide drop in demand for blood have left it in dire financial straits.

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."

Organising health care for all

New Nation (Learning Nation)
28/6-4/7/91.
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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.

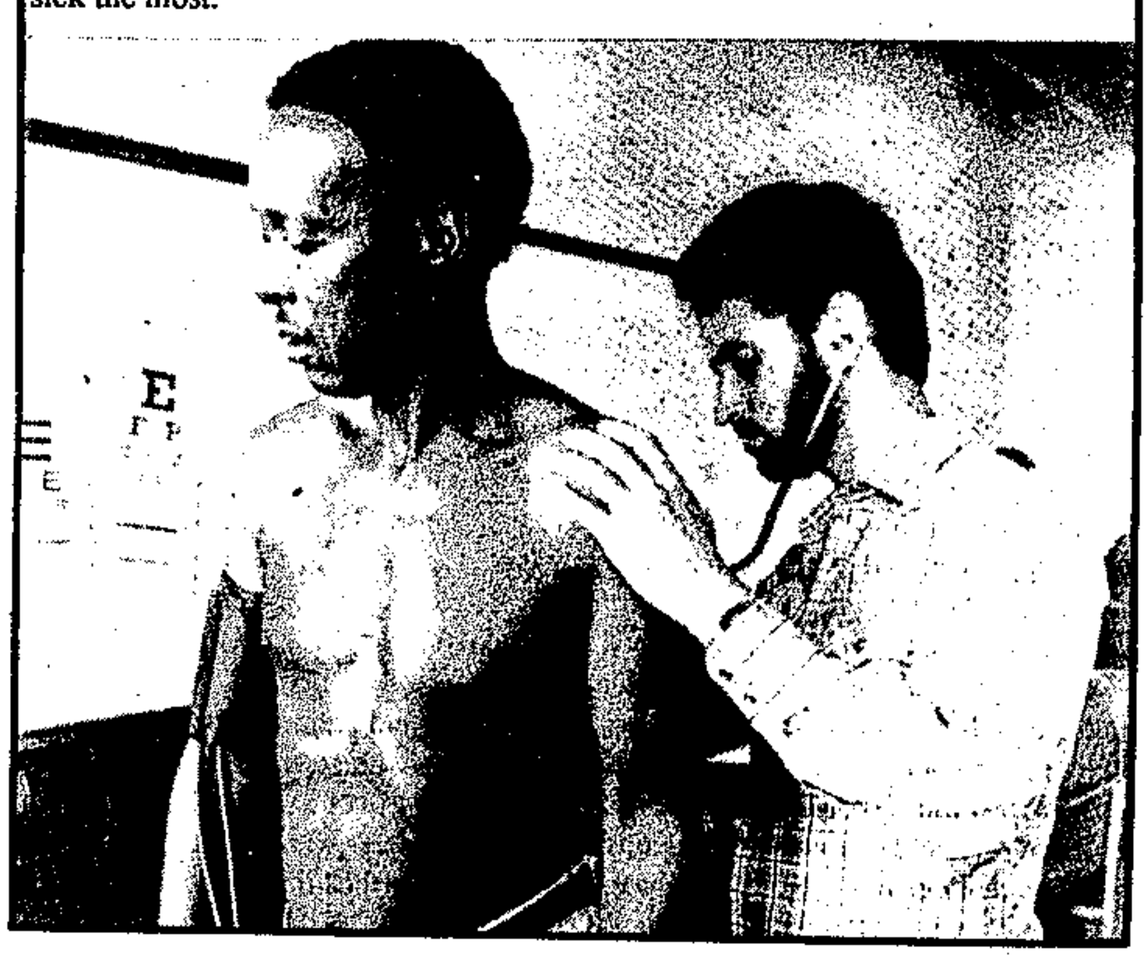
Even if black people were allowed to use all hospitals, the health care crisis would not be solved. **Health for All** will only come about when we understand why people become sick. Let us look at the story of Joe to understand how poverty makes people sick.

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.

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.

Nation's health put under the spotlight

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S Times 30/6/91 pg 1

By EVE VOSLOO

OVERSEAS experts will be among those addressing a conference on South Africa's public health services crisis at the University of the Western Cape next month.

The conference will focus on all aspects of community health, including social factors, environmental pollution, urbanisation, civil unrest, and medical issues such as AIDS, measles and tuberculosis.

"It's not just a medical conference — it's a health-related conference," Dr Derek Yach, chairman of the Epidemiological Society of South Africa and a Medical Research Council executive, said this week.

Dr Yach, who convened the conference, said most papers would focus on the community, and the strategies outlined involved issues such as environmental protection and health education.

Delegates represent World Health Organisation committees, community projects, government agencies, universities and research institutions.

The delegates include:

● Professor Richard Morrow of the Johns Hopkins University School of Hygiene and Public Health, Baltimore, US.

● Dr Olive Shisana, an exile who was previously with the National Centre for Health Statistics in the US and who has returned to South Africa to join the Medical Research Council.

● Dr Khanchit Limpakarnjanarat, the joint director of HIV-AIDS collaboration between the Thai Ministry of Public Health and the US Centres for Disease Control.

● Professor John Goldsmith, professor of epidemiology at Ben Gurion University of the Negev, Israel.

"Public health has been more isolated than clinical medicine in South Africa because it's so closely tied to government," Dr Yach said. "This is the first time it is opening up."

He said he hoped the conference would help shift awareness from clinical medicine to the community and prevention.

Taxing route to health

Own Correspondent

DURBAN — A national health service funded by taxes from "those who can afford them" is called for in an ANC discussion document.

The document, which will be debated at the organisation's annual conference at the University of Durban-Westville this week, says present health services reflect "all the injustices and irrationality of apartheid".

"No one should be excluded from public health services because they do not have money to pay," it says.

Only when this is achieved, would it be possible to reduce the different standards in health care.

The Government would therefore have to pay for health care and would have to tax those who could afford it to fund the national health service.

The document notes that there are major differences in access to good health care between black and white, rich and poor and urban and rural communities.

"The most advanced hospital care is inaccessible to the majority of people because of the costs and the time involved in travelling to the major urban centres where these hospitals are located."

A national health service would be:

- Unified and non-racial, and all communities should be provided with local clinics, community health centres and hospitals.
- Accessible and affordable — no one should be denied access to essential health care because the service is too far away or costs to much.
- Geared to giving priority to those most in need — children, mothers, the elderly, the mentally ill, unemployed, workers in hazardous situations and the disabled.
- Focused on eradicating or controlling major diseases such as Aids, tuberculosis, measles and polio.

squash court | h Hallett

VAT: Health to be exempted?

CT 4/7/91

From GILLIAN HAYNE

HANNESBURG. — Health services ght be exempted from VAT before e tax is introduced on September 0.

Inland Revenue chief director Mr Trevor van Heerden said VAT on health services was still under consideration. No decision had been taken.

He said a meeting had been held with the Dental Association of SA (Dasa), Minister of Finance Mr Barend du Plessis and Minister of National Health and Population Development Dr Rina Venter. A further meeting was scheduled for August 2.

Dasa president Dr Wynand Dreyer said in a statement yesterday the association was not fighting for a zero rating.

This was because "it seems unprofessional for the suppliers of health care to reap the benefits of the system without accepting its responsibility".

Zero rating would allow the profession to charge no VAT on services while still claiming a refund from revenue for VAT paid on inputs.

He said the dental profession was fighting for an exemption from VAT and would be prepared to absorb the additional costs of VAT on inputs.

Calculations indicate the burden to dental practices would be about 1,4% of turnover.

Dr Dreyer said the major reason health care should be exempt from VAT was that the cost of it would be unnecessarily increased. It would have a significant effect on "an already overburdened public health sector".

It would further strain the relationship between the health services industry and medical aid societies.

VAT would also place an unnecessary administrative burden on the suppliers of health services.

In an open letter to the profession, Dr Dreyer said members should attend seminars on VAT in case the tax was introduced on health services.

Family murders researched

Bl Day 10/7/91

PRETORIA — The majority of family murders in SA were caused by marital problems and depression, and were not an exclusive Afrikaner phenomenon, the Human Sciences Research Council (HSRC) said yesterday.

The HSRC findings by a three-year investigation showed there was no evidence to confirm the long-held theory that family murders occurred mainly among Afrikaners or whites.

A team of 20 researchers, led by Dr Louise Olivier, concluded that family slayings occurred in all racial communities and were generally caused by marital difficulties and depression, coupled with other problems.

The research also rejected theories that family slayings were linked to religious affiliations. As far as the researchers could ascertain the SA political system and community violence did not have a direct influence on the problem of family murders.

The report said that autumn appeared to be the favoured season for family murders with the murderer normally using a firearm. Most of the killers were between 24 and 35 years old. Men were twice as likely to commit family murders as women.

The report said the murderer's spouse usually had higher educational qualifications, tended to dominate the relationship, suffered from stress and was emotionally ambivalent, confrontational, disapproving, convictive and felt superior.

Own Correspondent

The researchers found there was no single solution to the problem and advocated an educational approach aimed at teaching people to cope with their problems.

The report made a number of recommendations including that couples planning to marry should receive martial counselling and psychologists should be permitted to advertise their services so that people with problems could know about the help available.

SA Medical and Dental Association spokesman Nico Prinsloo said the Professional Board of Psychologists would be meeting in August, where they would discuss the issue of advertising their services.

Researchers also studied 10 family murders in which the family murderer survived and was referred to a psychiatric institution for observation.

One of the recommendations of the HSRC's report is that family murder be recognised in law as a unique phenomenon: a move which would help with future research into family murders.

Search under way for new health plan

Pretoria Bureau Star 10/7/91

A model for a new health dispensation for South Africa, focused on decentralising health services, has been proposed at a conference of Ministers of health and welfare from South Africa and the self-governing territories.

It was proposed that it was time that attempts were made to arrange health services in such a way that they were more accessible and affordable.

A document said there were signs that the health status of inhabitants was deteriorating and that the present system was no longer affordable.

Local authorities, including regional services councils, should form the base of any future health dispensation — and all other services built on this base.

It was also established at the conference that the distribution of medical practitioners in the self-governing territories (Lebowa, QwaQwa, KwaZulu, Gazankulu, KwaNdebele and KaNgwane) was unsatisfactory compared with the rest of the country.

There was one doctor for 15 625 people in the six territories, against one doctor for every 1 099 in South Africa.

HEALTH MATTERS

Should traditional healers provide health care in South Africa?

(85) New Nation Learning Nation 12/7 – 18/7/91

12/7 – 18/7/91

A question which is often asked by people thinking about health care in South Africa is whether traditional healers should be allowed to provide health services. In today's article we do not answer "yes" or "no" to this question, but rather give some arguments from both sides of the debate and let you make up your own mind. Before presenting the debate, we give a short background on traditional healers in South Africa.

First, there is the traditional doctor or "**inyanga**". This is most often a male who uses herbal and other medical preparations for treating and preventing disease. Second the diviner, "**isangoma**", "**dingaka**" or "**amgqira**". This is most often a woman who operates within a traditional religious framework and acts as a medium with the ancestors. The traditional doctor and the diviner both provided health care in black communities long before any contact was made with white people. The third group who are generally considered to be traditional healers are the faith healers "**umpropheti**" or "**umthandazi**". This group of healers can be traced to the rise of the independent African church movement which broke away from the more western-oriented missionary churches. They can be regarded as traditional healers because they share common ideas about disease with other traditional healers, divine in a similar manner and treat diseases with traditional herbs and remedies. Officially, traditional healers are illegal in South Africa.

An act passed in 1974 outlawed any healer not registered with the South African Medical and Dental Council from providing health care. (Traditional healers are not registered with this body.) But in fact action is hardly ever taken against traditional healers and one can possibly say that they are "unofficially recognised". Though they are not part of the formal health system, most people in rural areas in South Africa and even in the townships know where to find traditional healers if they want to make use of them. And even though there is no official recognition, there are a number of organisations which represent traditional healers in South Africa. These include the Southern African Traditional Healers Council, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Doctors of Southern Africa, the African Dingaka Association and the African Skilled Herbalist Association. Though no-one knows exactly how many traditional healers there are in South Africa, it has been estimated that there may be as many as 150 000. Now on to the debate which we spoke about.

Arguments in favour of traditional healing

- Traditional healing is part of African culture. Africans have a right to protect and promote their heritage, and traditional healers do this. There are also illnesses which are said to have particularly African causes and that no amount of modern health care can help with such problems.
- There is a lack of health care resources in South Africa and traditional healers are an accepted, accessible and influential grouping in many black communities.
- Traditional healers provide a **holistic** form of healing which involves the person **both** as a spiritual **and** a physical being (as opposed to most modern health care where almost the whole emphasis is on the person's physical state). Traditional healers help the person live at peace with family, village, tribe and inner-self.
- Traditional methods are known to be effective and many people are cured. It is sometimes said that this is reason enough to encourage use of traditional healers.

Arguments against traditional healing

- One of the strongest arguments against traditional healers is that many of their practices can be harmful to the patient. Modern doctors have pointed out for example that using enemas to treat and prevent diarrhoea, making people with weak hearts or tuberculosis (TB) vomit, using unclean razors for vaccinations, as well as other methods used by traditional healers, are often very dangerous.
- Traditional healing is primitive and the explanations given are simply wrong. It is even said by influential people in black communities, such as Dr Nthato Motlana, that traditional healing is "mumbo-jumbo" and through promoting it black people are kept from developing in the modern world.
- Traditional healing sometimes creates community disharmony, For example, a person's illness is on occasion said to be caused by another member of that community and in some instances this may even lead to the death of a person in that community.
- Traditional healing may be autocratic because much of the healing force that a traditional healer has comes from the fact that she/he is seen as having a lot of power. For this reason some people argue that traditional healing does not promote democracy and empowerment. While much of modern medicine also operates on autocratic principles where the doctor is treated as a "little god", the actual healing powers of doctors are generally not dependent on the autocratic power of the doctor, whereas the traditional healer is dependent on this power.

What policies have other African countries adopted?

Most African countries changed the "colonial" policies around traditional healing after they achieved independence. They have not, however, taken a unified direction. It is interesting to look at the very different policies adopted by two countries on our borders: Mozambique and Zimbabwe.

After independence, Mozambique took a strong stand against traditional healers. **They were seen to be part of an old feudal system, furthering superstition rather than scientific socialism and were liable to exploit the poor.** In spite of this policy, more than half the population continued to use traditional healers. The policy also caused tension between the government and the people. These factors recently forced the government to change its view and now people are free to choose the health care they want and traditional healers' associations are encouraged. But traditional healers are still not part of the formal health system.

In Zimbabwe on the other hand, traditional healers were officially recognised after independence. They were requested to register with the Zimbabwe National Traditional Healers' Association and encouraged to cooperate with the modern health sector. This policy also did not produce the expected results. Many traditional healers are still not registered with the official body and there has not been as much cooperation with modern health care as was expected.

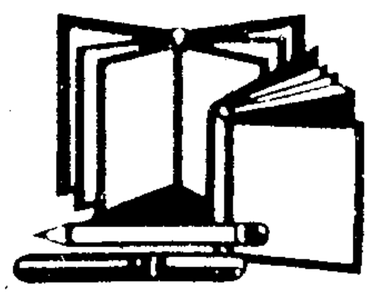
Conclusion

We have seen in this article that there are probably good and bad points to the continued use and recognition of traditional healers. It must be realised, though, that if a policy of official recognition is adopted there are likely to be many practical problems. For example, one would have to be sure that only well-trained and "real" traditional healers were allowed to register and practise. Unlike the training of modern doctors, traditional healers do not have a formal "school" where only those who qualify from the school can register. Also there is a lot of secrecy in the way that many traditional healers practise and therefore it would be extremely difficult to "test" people to see if they are genuine healers or not.

After independence in South Africa, we too will have to make choices as to whether and how traditional healers should be allowed to practise. **What do you think?** Write your views in to **Learning Nation**, P.O. Box 11350, Johannesburg, 2000.

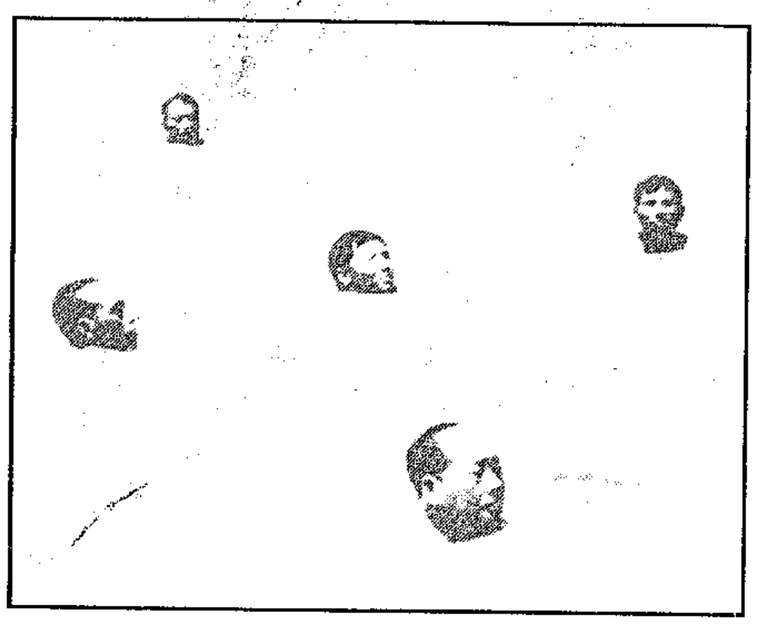
This article was written by OASSSA.

SKILLS FOR LEARNING



Our address is:
Learning Nation
PO Box 11350
Johannesburg 2000.
Phone: (011) 23-9746.

Mao Tse Tung believed that swimming helped to build a person's physical and spiritual strength. Here we see him swimming across the Yangtze river - one of the biggest rivers in China. in picture 5, we see hundreds of young people swimming after him across the river.



Picture Four

6) Why do you think the young people are copying Mao in this way?

7) From what you have learnt, what type of personality do you think Mao had? Think of at least four adjectives to describe his personality.

8) Would you call what Mao is doing 'leadership by example'? Why?

Picture Five

9) can you think of anyone in your own community who leads by his or her example? Briefly describe this person.

Picture 6 was taken at a factory in China. We can see hundreds of statues of Mao waiting to be packed. (Some are already in boxes.)

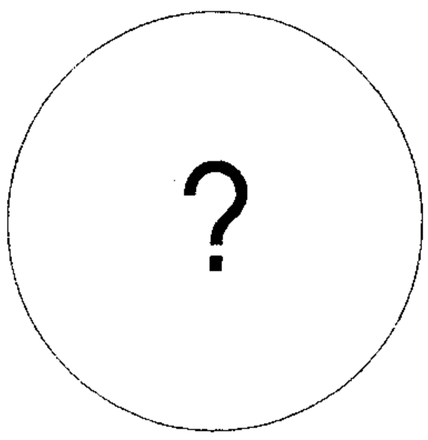
For discussion:

10) It is not clear what material these statues are made of. It could be stone, or maybe plastic. What do you think would be the best material for such statues?

11) Why do you think the statues come in different sizes?

12) If you could buy a statue or a picture of your favourite political leader, would you? Explain why or why not?

Who else do you think is a Personality Cult figure ? Send a picture of that person in to Learning Nation, P.O. Box 11350, Johannesburg, 2000.



Picture Six

A Personality Cult is a form of leadership which comes about for many reasons. Here are a few: An unusually strong leader decides that he or she alone knows what is best for the people ;people are relieved not to have to make their own political decisions and decide to leave it up to a strong leader who will show the way; people don't have faith in their own thoughts - maybe they fear to express their thoughts or maybe they basically agree with a leader and don't want to disagree on particular issues because it seems disloyal to do so.

Points for discussion:

1) Is it necessary or important to lead by example?
2) What is democratic leadership? Can it include leading by example?
3) Who do you think is most responsible for personality cults - people who seem to follow their leaders blindly, or those leaders themselves. Explain your answer.
4) What is more important in a good leader - good organisational skills or the ability to speak well?

Write to Learning Nation at P.O box 11350, Johannesburg, 2000, and tell us what you think. We will use your responses in a follow-up article on "Styles of Leadership"

Design guide aims at cost-effective clinics

PRETORIA. — A support-system guide aimed at maximising funds allocated to primary health care in South Africa was yesterday handed to the Minister of Health, Dr Rina Venter, by the Council for Scientific and Industrial Research (CSIR).

In his address, the director of the CSIR's division of building technology, Mr Roy Page-Shipp, said the Design Guide for Primary Health Care represented two years of joint efforts between the CSIR and the Department of National Health.

The guide provided a complete background of the service to be accommodated and could be used by the facility planner to develop the project brief. It would also provide designers with solutions for the cost-effective and efficient design of clinics.

The hard-copy Design Guide is supported by a computer-aided design version called Medicad. — Sapa

85 CT 16/7/91

Misuse of antibiotics common

CT 16/7/84

Staff Reporter

THE incorrect use of antibiotics in Groote Schuur Hospital was found to be as high as 54% in some departments, a survey disclosed last week.

A report in the latest SA Medical Journal said antibiotics "comprise a substantial proportion" of drug expenditure and the misuse not only increases the cost of patient care, but also the prevalence of resistant organisms.

The authors said: "Inappropriate use of antibiotics imposes a substantial economic burden on health care systems."

The article says the survey found the greatest number of wrong prescriptions (54%) in the gynaecology ward.

University of Cape Town Professor of Microbiology Arderne Forder said antibiotic overuse is a worldwide phenomenon.

"Because they have few toxins there are few side-effects and a doctor faced with a sick child will prescribe antibiotics to cover the suspected illness," he said.

'Health research needs major direction change'

(85) ARG 16/7/91

HANS-PETER BAKKER
Staff Reporter

HEALTH research is in need of a major change in direction, says Dr Philip van Heerden, president of the Medical Research Council.

Dr Van Heerden delivered the keynote address — on the future of health research in Southern Africa — at the closing of the 10th Epidemiological Conference at the University of the Western Cape.

He said the board of the MRC "has given the go-ahead to move away from a rigid institute-based approach toward a more flexible programme structure" which integrated the activities of the MRC with those of the academic institutions, the health services, non-governmental organisations, and the general public.

According to Dr Van Heerden, the MRC realised at the beginning of 1990 that the council was "not really addressing the country's health needs".

He said a "concerted and well-structured attempt to organise health research was still lacking".

The MRC was now setting research priorities.

"We need a portfolio of well-structured research programmes in which we harness all available human resources and infrastructures," he said.

HRCT 19/7/91

Pay on the spot plan for patients

85

299

The Argus Correspondent

JOHANNESBURG. — Medical aid patients will have to pay medical bills up front if draft legislation proposed by the government is approved.

In some cases, where a patient undergoes an expensive procedure like X-rays or radiological tests, patients will have to fork over hundreds of rands, which they will then have to claim from their medical aid schemes.

The draft legislation proposes that medical aids no longer pay doctors or medical service suppliers directly, but deal only with patients, who will be reimbursed according to the set medical aid scale of benefits.

The Dental Association of South Africa and the Medical Association of South Africa yesterday confirmed that the government had asked them for their opinion before the draft Bill is passed.

The director of the Medical Association of South Africa's professioal services, Dr Martin de Villiers yesterday said it had been argued in the past that guaranteed payment by medical aid schemes had resulted in over-servicing by doctors and overuse by patients.

Dr De Villiers said a system where monies were paid directly to a patient could lead to them spending their benefits on things other than medical bills.

He said retaining guaranteed payment and offering patients no-claim bonuses would prove a more effective means of addressing the problem of abuse of benefits.

A representative of the Dental Association of South Africa (Dasa) said members of medical schemes received benefits according to a scale determined by the Representative Association of Medical Schemes (Rams).

He said the scale had not kept pace with the increasing costs of dental practice and therefore members of Dasa used the national schedule of fees determined by Dasa as a guide.

A dentist said the abolition of the guarantee would result in lower income groups being deprived of private sector oral health services. It would also have a tremendous negative effect on practitioners.

However, he said, the guarantee was "a curse" in his profession as it had led to many cases of malpractice such as over-servicing, something that was openly admitted by certain members.

The national president of the Housewives League, Mrs Lyn Morris, strongly condemned the proposed amendment. She said health was one of the basic things in life and everyone should be able to afford it.

She had a degree of sympathy with doctors who often had to wait months for the medical aid to settle the accounts but said to punish the member was unfair.

"People pay medical aid as a form of insurance. They pay it knowing treatment would be paid for if an operation or other treatment was needed. But they will not be able to afford medical services any more if payment is demanded immediately after treatment."

National unity bid

CT 22/7/91

ABOUT 400 delegates at the first joint national progressive health workers' conference decided at the weekend to form a single controlling body.

The delegates included members of the National Medical and Dental Association (Namda), the Organisation for Appropriate Social Services in South Africa (OASSSA) and the Progressive Primary Health Care Network (PPHC).

This was confirmed yesterday by Mr Michael O'Brien, a spokesman for the organising committee, after the weekend-long conference ended at the University of the Western Cape where medical staff, social workers, psychologists and primary care health workers and nurses were represented.

The conference was held to identify and work out the problems in health care in South Africa; to establish the role of primary health care as the most important issue, and to work toward unity between the various bodies.

The three themes were: Equity, finance and control; personnel and workers' issues, and the integration of all the various bodies into a unified primary health care system, Mr O'Brien said.

Brain drain 'will hobble growth'

GERALD REILLY

PRETORIA — The drain of professional and skilled workers would be a serious constraint on growth once SA's economy started to pick up, experts warned yesterday.

They were reacting to a Market Research Africa survey which disclosed that more than 250 000 white SA adults saw themselves as potential emigrants.

Central Statistical Service figures show SA has lost 315 medical doctors, 807 accountants and 1 349 engineers since 1986.

However the total loss of 7 800 professional, semi-professional and technical personnel in the five years is balanced to some extent by almost the same number of immigrants in these categories.

I R Scott, president of the SA Association of Consulting Engineers, said that while Japan had 500 engineers per million people, the US 370 and Europe 280, SA had only 35. B|Day 24|7|91

"If a new SA is to take its rightful lead in the development of southern Africa, it will have to attract engineers from abroad and undertake a massive education drive," he said.

National Personnel Institute economist Jan de Jager said with sanctions easing, SA could soon move out of the economic stagnation of the past two years. The skills drain would hobble growth.

White Paper on tourism expected

B|Day 24|7|91.

MARCIA KLEIN

SIGNIFICANT changes to SA tourism are expected following yesterday's release of a "strategic framework" for the industry.

The Strategic Framework for Tourism Development in South and Southern Africa, which provides principles and guidelines for the future development of SA's tourist industry, was produced by the SA Tourism Board (Satour) and the Development Bank of SA.

Their proposals, with a report produced by the Board of Trade and Industry last year, would be considered by Minister of Trade and Industry and Tourism Org Marais and his department, and a White Paper would be issued by the end of August, outlining government's response.

The framework outlined three major institutional adjustments, including establishment of a community-driven structure to ensure "bottom-up participation" from various regions.

The second adjustment was Satour's repositioning. An international marketing arm would promote SA generically, and Satour would shift its focus to development.

The framework also suggested a Cabinet committee be established "to facilitate co-ordinated management of tourism by public sector institutions on a national basis".

Satour chairman Piet van Hoven said his organisation would implement action suggested in the framework immediately. Recommendations which required government sanction would be dealt with by way of a White Paper.

The document said the tourism industry, which employed more than 300 000 people and earned R2,5bn in forex in 1990, was "of strategic and economic significance to SA". Tourism was a labour-intensive industry, had a strong multiplier effect, and had forex earnings potential.

Extensive growth in the industry had not occured because of its sensitivity to the investment climate, sensitivity to apartheid, and the need for personal safety. International arrivals had increased 19% between 1958 and 1975, and had slumped to 1,14% between 1975 to 1989.

With current trends towards a more normalised market situation, significant growth in the industry could be achieved. It was critical that the industry be carefully managed.

Tourism in SA was insignificant in terms of the contribution the industry made elsewhere in the world.

United anti-apartheid health organisation to be formed

B|Day 24|7|91

TANIA LEVY

ANTI-apartheid health organisations will unite in their fight to replace discriminatory health services with a more acceptable system.

At a news conference in Johannesburg yesterday, the SA Health Workers' Congress (Sahwco), the National Medical and Dental Association (Namda), the Organisation of Appropriate Social Services in SA and the Health Workers' Society announced that a formal decision on unity had been taken at the weekend.

The four organisations would formally dissolve early in December and the new united organisation would be launched in March.

Its aims include eradicating discrimination in health and welfare services, unifying the various health disciplines, promoting equality and appropriate training for health workers and protecting the standard of health and social services in SA.

Namda president Mvuyo Tom said the unified national organisation would present a "formidable front to advance the struggle for equal health for all".

Until now government had been able to exploit the space created by the fragmentation of the progressive health sector, he said.

Together the four organisations have a paid-up membership of more than 4 000 people and an active campaign will take place in the next six months to include as many other health organisations as possible.

A name and constitution for the new body would be decided on in due course.

Tom said unification would allow the progressive health sector to pool resources and to use funds, from both local and international sources, more efficiently.

The EC and the Kaiser Foundation in the US had been among foreign donors which had funded the organisation's projects and conferences in the past, he said.

Council action sparks stayaway

WILSON ZWANE

BUSINESS in Nigel, on the East Rand, has been hit by an indefinite stayaway called by the Duduza Civic Association (DCA) in retaliation to the local town council's decision to seize the property of four rent defaulters.

DCA official Saki Kekana said yesterday the stayaway, which enters its third day today, was "100% effective".

It would be maintained until the council returned the property it had seized.

Nigel Chamber of Commerce chairman Bernard Fitton said the stayaway had been about 70% effective. B|Day 24|7|91

"We are to recommend to our members adoption of a no-work-no-pay policy," he said.

He would not say how hard businesses in the town had been hit by the stayaway.

The Duduza Town Council could not be reached for comment.

Health groups to merge

(85)

Sowetan 25/7/91

FOUR organisations involved with community health are to merge and launch a single body by next year.

By DON SEOKANE

The National Mental and Dental Association, Health Workers Society of Western Cape, South African Health Workers Congress and the Organisation for Appropriate Social Services in South Africa began formal talks in 1989 in a bid to achieve unity among health groups campaigning against an unjust health care system.

A national unity conference of the four groups was held last weekend to finalise the unity process and it was decided to launch a new organisation in March next year.

The four organisations will formally dissolve and suspend their constitutions in December before the launching of the new organisation.

At a Press briefing in Johannesburg yesterday, Namda's president, Dr Mvuyo Tom, said the four organisations had decided to unite because the State and its organs had been taking advantage of the "fragmentation of the progressive health sector".

Health care can 'never be equal'

(85) ARGUS 26/7/91

VIVIEN HORLER
Medical Reporter

A MEDICAL financial consultant says equal health care for all South Africans is a pipe dream, and a more natural conclusion would be "he who can afford, gets. He who can't, doesn't".

Mr Mike Edwards, of M A Edwards and Associates in Claremont, told The Argus: "No cynicism is intended. That is merely the situation as I see it.

"I can see the challenge, but I can't see the solution. I hope better brains than mine can see it."

Mr Edwards, who advises doctors around South Africa, was commenting on an article he has written in the latest SA Medical Journal, in which he says:

"The conclusion has to be First World medicine for First World patients and Third World medicine for Third World patients.

"To marry the two worlds is like trying to mix water with oil. They don't mix, and at best you get the current murky mess."

He said he would like to see First World standards apply to all South Africans "but surely this is a pipe dream? An inevitable Hippocratic hypocrisy? It is just not possible.

"We have teaching hospitals facing drastic cutbacks, closure of wards, reduction of facilities, all in a time of great political change. We have a government that is aware of the problem but which seems to be unable to provide solutions."

He foresaw a future government levying higher taxes to provide more equitable distribution of wealth with greater social benefits. This would mean, in the short-term, that state hospitals and clinics would get more funds. "It will be left to time to defeat the fine ideals."

But in the long term, as had been shown in Zimbabwe, he said, the system did not work, and doctors emigrated.

He felt sorry for doctors who had "sold their souls for guaranteed payments and charge Scale of Benefit fees", because their guaranteed payment, their patients and the medical aid schemes would fall away.

"Those private doctors who have the strength of their own convictions and who have carved a place for themselves in the capitalistic society by charging what they, or their association, feels that they are worth, will always have a market.

"The market may get marginally smaller, but there will always be a place in society for those who can provide health care of the highest standards ... at a price."

Commenting on his article, Mr Edwards cited the example that not everyone who needed kidney dialysis was able to get it, because there were not enough machines.

Health care bodies form alliance

(86)

ST 30/7/91

JOHANNESBURG. — Mutual hostilities between progressive health care organisations and the Medical Association of South Africa have been put aside and a tactical alliance has been formed between them.

The organisations are the South African Health Workers' Congress, the National Medical and Dental Association and Masa.

The hostilities between the progressive sector and Masa arose from the death in detention of black consciousness activist Mr Steve Biko in 1977.

Sahwco spokesman Dr Aslam Dasoo said the interaction between the organisations began in February last year and they had since worked jointly. — Sapa

Shot in the arm for health care in Jo'burg

Star 1/8/91.

A new concept in health care has originated in Johannesburg. Municipal Reporter LOUISE BURGERS reports.

THE Johannesburg City Council has the entire city's health at heart. An outreach programme to address community health and a radical Aids programme were launched a year ago.

Johannesburg is recognised as having one of the finest Aids programmes in the country and has received international recognition for its work. More recently, material on the council's Aids programme was requested by the USSR, Spain and Cuba.

Health officials have also been asked to present papers in cities across the United States, Canada, Gabon, Zaire and South America.

Johannesburg health and housing director and medical officer of health-elect, Dr Nicky Padayachee, said the council was trying to teach people to treat themselves.

"The whole concept of health has changed. We have moved away from the idea of disease as a medical condition requiring therapeutic intervention to a concept of total health care and the treatment of the economic, social and mental well-being of communities.

"This is in keeping with the World Health Organisation approach and international trends.

"All factors are tied up with environmental well-being. If we continue as we are, the country will have to pay out R60 billion alone in Aids care at the turn of the century. This is horrific — it is six times South Africa's total health bill.

"That is why we have to intervene now. We've looked at the first decade of the Aids epidemic — now we have to use innovative methods to change people's attitudes."

In a report released recently, health researchers of the Medical Research Council and the Centre for Health Policy of the University of the Witwatersrand estimate that 5,2 million people could be infected with the Aids virus by the year 2000.

In the worst scenario, they predicted that by the year 2005, 2,9 million cumulative deaths from Aids could have occurred and the number of HIV-infected people could have reached 7,4 million.

Dr Padayachee believes the shocking scenarios presented by study groups recently can be prevented. He paid tribute to the council's management committee for its understanding of the Aids issue.

The initial cost of the outreach programme is R500 000. It will cost about R600 000 a year to run. The Aids programme costs more than R1 million a year to operate.

Dr Padayachee said City Health had been restructured to include in a single department health, urbanisation and housing.

"In the next 10 to 20 years, the well-being of cities will be very important. The crux is to empower families and communities with control over their lives and environment.

"For example, it is no use treating a child's pneumonia or bronchitis every time without treating the cause, which could be a draughty shack," Dr Padayachee said.

"We are not only treating the symptoms, but the total conditions underlying the problem."

The first outreach centre opened six months ago at 17 Esselen Street, Hillbrow. It includes a family-planning clinic, counselling service, free testing for Aids and other sexually transmitted diseases, and it distributes condoms for free.

Dr Padayachee said: "Most basic health problems can be taken care of by individuals."

People who knew how to access clinic and hospital-based services were not necessarily the ones who needed them the most, and the council had to try to take health care to people such as drug abusers, sex workers, the unemployed, shack dwellers and others.

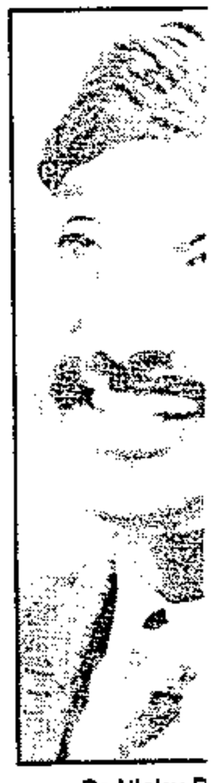
"Aids, for example, is a specific issue. We have to go to communities and educate them concerning the dangers of Aids without waiting for HIV-positive patients to come to us."

Dr Padayachee said it was difficult to measure the success rate of the outreach and the Aids programme. "We have managed to gain access to, and the confidence of, marginalised communities."

The council's aim is to extend the outreach clinics throughout the city.

Actors are employed in a play on Aids education, a cabaret show is being organised for nightclubs, and the council has backed marches on Aids Awareness Day. An advertisement for cinemas and electronic billboards with Aids messages have also been produced.

Johannesburg has offered to train staff at the Soweto, Deipmeadow, Dobsonville and Alexandra town councils. □



Dr Nicky P

Small clinic gets a healthy start

Star 1/8/91

(85)

A planned new Atteridgeville clinic shows the fruits of co-operation between the community, local authorities, Pretoria University and the private sector.

If knowledge is power and unity is strength, then a small clinic just outside Pretoria should be a medical venture with enough resources to pioneer a new era in urban primary health care.

The Sebideng Health Centre project, taking place in a disused beerhall in Atteridgeville, is distinguished by the remarkable degree of co-operation so far between the community, local authorities, Pretoria University academic departments and the private sector.

The venue is undergoing renovations, thanks to a R40 000 donation from a pharmaceutical company. Pretoria University's architecture department is designing and supervising the renovations.

Dr Magriet Loock, of the university's faculty of medicine, who also heads the clinic, says the project has brought together all the vital players: the Pretoria medical faculty, the Atteridgeville Saulsville Residents' Association, the Department of National Health, the Transvaal Provincal Administration, local authorities, volunteers from the Atteridgeville Retired Nurses Society and the Sandoz pharmaceutical company.

Dr Loock says: "We are trying to co-ordinate an integrated package of advice and support to change community health here."

The centre was originally opened in January 1990 after a group of doctors at Dalafong Hospital, Atteridgeville, identified the need for a hypertension and cardiovascular screening clinic in the area.

Dr Loock says: "Once we diagnose in hospital it is often too late. Strokes, kidney failure, heart attacks are the result of conditions that develop over a long time.

"We estimate 25 percent of this community suffers from hypertension, for example. The only way to deal with that is through prevention or early diagnosis and education about diet and lifestyle."

The clinic will also be a first-contact clinic to manage routine minor illnesses, she says.

Roger Trythall, of Sandoz, says his company sponsored the project because first line health care is vital.

"It is imperative to 'download' the hospitals in South Africa, where treatment is expensive.

"Once a person gets to the hospital stage it is unlikely he will return to be productive in the community.

"It is cheaper to seek out symptoms early where treatment is more cost effective and successful.

"More private sector companies should be involved," he says.

ADAM GORDON

Pulling together ... members of the clinic project team include (from left): Roger Trythall, Dr Magriet Loock and Michael Kganakga, chairman of the Atteridgeville-Saulsville Residents' Organisation. Pictures: Adam Gordon.

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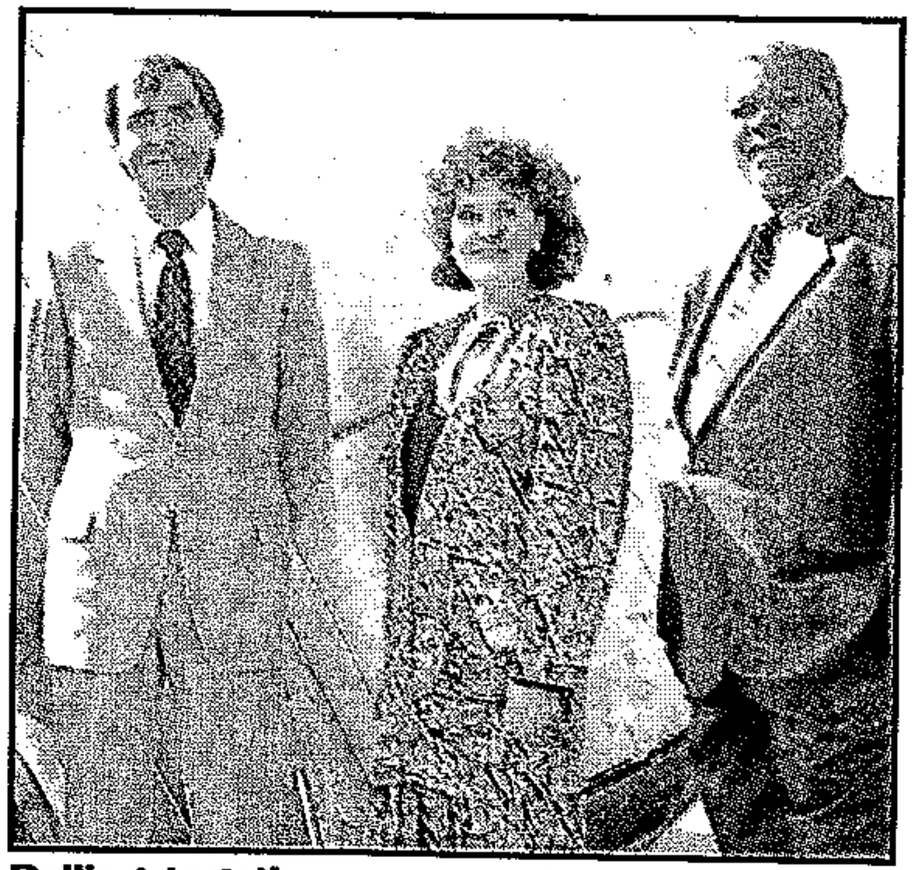


Pulling together . . . members of the clinic project team include (from left): Roger Trythall, Dr Magriet Loock and Michael Kganakga, chairman of the Atteridgeville-Saulsville Residents' Organisation. Pictures: Adam Gordon.

Local blood exported to East London

EAST LONDON. — Blood from predominantly white low ... donors in Cape Town is being "exported" to ... Border area.

This is because there is currently "no clear-cut low-risk donor group" in the black community, the head of the Border Blood Transfusion Service, Mr G du Toit, said yesterday.

The "low-risk" category comprised donors with the least possible risk of being infected with Human Immuno-deficiency Virus (HIV).

He said blood was being imported to cover a shortfall resulting from a new policy to accept blood exclusively from "low-risk" donors.

Statistics released by the Department of National Health and Population Development in May 1991, indicated that since 1982, the incidence of HIV-positive cases was higher in the heterosexual black community than in its white equivalent.

WP Blood Transfusion Service medical director Dr Arthur Bird said last night that high- and low-risk categories of donors were determined by means of a confidential questionnaire all donors were obliged to complete.

He said donors were not excluded on the basis of race. "In the Western Cape our blood donors are largely white, followed by coloured and Asian and then a smaller percentage of black people.

"We do not exclude donors on the basis of colour, but on the basis of risk categories — nor do we dish out blood on that basis." — Own Correspondent and Staff Reporter

Old drug may save thousands

(85) CT 2/8/91

BOSTON. — Treatment with a drug that prevents blood vessels from narrowing can significantly increase the survival rates of patients with long-term congestive heart failure, according to two new studies.

The studies, published in yesterday's New England Journal of Medicine, provide the first clear evidence that a class of drug known as ACE-inhibitors can help save the lives of thousands of patients with chronic congestive heart failure.

ACE-inhibitors work by blocking the constriction of blood vessels. Although available for years, they have been prescribed to only about 20% of such patients, usually only when conventional treatments failed, because there was insufficient evidence of their effectiveness.

The drug used in the studies was Vasotec which, with Vaseretic, is one of two brands of the ACE-inhibitor enalapril.

In one study doctors from 83 hospitals in the United States, Canada and Belgium found that enalapril, when combined with conventional treatment, lowered the risk of death by one-sixth and reduced hospitalisation by nearly one-third.

"Not only did this drug make chronic heart failure patients feel better, it improved their survival and kept them out of hospital," said study leader Dr Salim Yusuf of the National Heart, Lung, and Blood Institute.

In the second study, led by Dr Jay Cohn of the University of Minnesota Medical School, researchers found that the death rate was 25% with standard drug treatment compared with 18% among those given enalapril as well. — Sapa-Reuter

Barend asked: 'Leave VAT off medicine'

86 2

Staff Reporter CT 3/8/91

AN open letter to Minister of Finance Mr Barend du Plessis has pleaded that Value Added Tax (VAT) should not be levied on medical and dental services.

Mrs Lynn Morris, president of the Housewives' League of South Africa, sent the letter in a "last-ditch stand" for exemption from the tax which replaces sales tax in October.

Mrs Morris said VAT in principle would be "expedient and beneficial" but if introduced at such a high rate would not be in the interests of "people's medical well-being".

Medscheme chairman Mr Keith Hollis said on Thursday that many schemes were looking at increasing rates by 25% to 30%, and this was partly due to VAT.

Mrs Morris said: "If living standards must be lowered at least grant us a modicum of security in the knowledge that medical care will not be taxed beyond our means."

Mr Du Plessis could not be reached for comment.

Cape Times,

'Medical ethics compromise research'

(85) CT 8/8/91

Staff Reporter

MEDICAL ethics compromise surgical research, University of Cape Town Professor P C Bornman said in his inaugural lecture at the Education Building yesterday.

Speaking on "Surgery and modern technology — finding the balance", Prof Bornman said surgeons faced difficult pressures from "medical ethicists on the one hand and lawyers with vested interests on the other".

He said: "The issues involved have reached a stage where they might compromise essential clinical research."

Protection of human rights had prevented investigators and patients from participating in clinical trials, "thus seriously reducing the rate at which new knowledge is acquired".

Prof Bornman said the demise of clinical investigation could be correlated directly with the rise of the human-rights movements in the 1960s.

The ethical issues in countries such as Holland and Germany had made it "virtually impossible to do controlled trials", he said.

Prof Bornman cited treatment of breast cancer as being retarded through medical ethics.

He said only a small number of eligible patients could be admitted to a study on lumpectomy, which means the simple removal of the cancer lump with the preservation of the breast.

The alternative and used method was the total removal of the cancer-baring breast.

He said the attitude of doctors was summed up by one who said: "How can a physician committed to doing what he thinks best for each patient, tell a woman with breast cancer that he is choosing her treatment by something like a coin toss?"

Problems of health care spotlighted

Medical Reporter (85) ARG 8/8/91

TWO top State hospital doctors are to look at the problems in South Africa's health care services at a public lecture next week.

Professor Solly Benatar, professor of medicine at UCT and Groote Schuur Hospital, and Dr Gilbert Lawrence, medical superintendent of the Red Cross Children's Hospital, will speak at a meeting organised by the Institute of Race Relations.

Mr John McRobert, chairman of the Cape Western region of the institute, said the organisation was "tremendously concerned" about health care in South Africa.

The lecture is at 8pm on August 15 in the Leslie Building, UCT upper campus.

Medics to meet over 'inhuman tax on sick'

Star 14/8/91

(85)

By Carina le Grange and Own Correspondent

VAT AND YOU

The medical profession is making last-minute attempts to prevent VAT on medical services.

A few days ago the Medical Association of South Africa (Masa) met Minister of Finance Barend du Plessis to discuss VAT.

In Cape Town, up to 400 western Cape doctors are expected at a protest meeting tonight against the "inhuman imposition of VAT on sick people".

The Society of Dispensing Family Practitioners has already launched a countrywide petition.

The Dental Association of South Africa has also met Mr du Plessis.

It is understood the Minister will announce this week whether appeals for VAT not to be standard-rated — at 12 percent, such as other services — has been successful.

Masa said yesterday it had asked Mr du Plessis at the latest meeting to review the decision to standard-rate medical services and to postpone the implementation until all possible negative results on health care had been eliminated.

Masa again appealed for the VAT zero-rating on medical services.

Masa chairman Dr Bernard Mandell said it could result in more and more patients — including medical scheme members requiring expensive treatment, and the chronically ill — turning to the State because benefits would not cover their expenses in full.

He added that poor patients without medical aid who were treated at reduced rates in the private sector would also not be able to cope with cost increases.

The organiser of the Cape Town meeting, Dr Tony Behrman, said he believed VAT would make it increasingly difficult for the "impoverished 60 percent of the population to seek medical care".

"They will delay consulting a doctor until their problem is more grave."

● A zero-rating means doctors would be able to claim back the VAT charged on their input charges such as electricity, equipment, rent and telephone bills, and would charge patients VAT at nil percent.

VAT raises fears over health care

(85) GERALD REILLY

PRETORIA — The Medical Association of SA (Masa) is concerned that government's R220m poverty safety net will not be in place when VAT is introduced on September 30. BIOmy 15/8/91

Masa federal council chairman Bernard Mandell said there was also concern that the amount available would be insufficient to provide relief to offset the impact on health sevices, let alone compensate for the tax's overall impact.

Mandell said Masa had again appealed to Finance Minister Barend du Plessis to zero-rate medical services.

Du Plessis was asked to at least postpone its implementation until possible negative results on health care had been eliminated.

Mandell said Masa was concerned that VAT would make health care less accessible to patients.

This would have far-reaching implications for the state.

Medical scheme members needing costly treatment and the chronically ill would turn to the state because benefits failed to cover cost.

Poor patients without medical aid would not be able to cope with cost increases resulting from VAT.

VAT could have a greater impact on the private sector costs incurred by public sector patients who were subsidised by the state.

This could strenghten the demand for a national health system.

Mandell said other proposals made to Du Plessis were tax relief on medical expenses, adjustment of the means tests and the increase of the public health budget by an amount equal to the VAT collected from this source.

The introduction of a national health insurance fund to ensure all patients would have access to essential and life-saving services was another.

Masa also asked for the funding of a national consensus forum working towards the design of an efficient and equitable health-care system.

... prices also hurt ... farmers ...

75% of jobs from small firms

BJDay 16/8/91

PORT ELIZABETH — The small business sector generated 75% of new jobs in SA, said Port Elizabeth Small Business Development Corporation manager George Marriner in a statement yesterday.

As more than 85% of all business enterprises in SA could be considered small, with total assets of about R2m, this was not surprising, he said.

"Forty percent of overall economic activity in SA can be accredited to small-scale enterprises in both the formal and informal sectors.

"Small businesses are a low-cost means of providing employment and are an efficient way to utilise resources in the economy." — Sapa.

Venter and union agree strikes are 'undesirable'

VERA VON LIERES

THE National Education Health and Allied Workers' Union (Nehawu) said yesterday it had held "positive talks" with Health Minister Rina Venter over a number of health issues, among them the lack of proper consultation in the sector.

BJDay 16/8/91

Nehawu national organiser Monde Mditshwa said the parties met yesterday to discuss a number of issues, including the question of disciplinary action taken by the SA Nursing Council after the May 1990 nurses' strike.

"The axe is still hanging over the nurses' heads," Mditshwa said.

Disciplinary action by the Nursing Council would hamper the relationship between the authorities and the union and the rendering of services.

Mditshwe said the parties agreed strikes in the health sector were not desirable. Nehawu gave assurances it was in no way compromising services, but said legitimate grievances gave rise to the 1990 strike. These had not yet been resolved.

The parties are expected to issue a joint statement next week.

Finance

Government now 'punishing people for getting sick'

W|Mail 16|8–22|8|91

85

The standard rating of health services under Value Added Tax is adding to the medical profession's woes, reports **MONDLI MAKHANYA**

THE charging of Value Added Tax on health care is being vociferously opposed by the medical profession.

The inflationary pressure resultant from the VAT standard rating will put health care out of reach of most people. Groupings in the medical field have made representations to the government to zero-rate medical services.

The VAT factor comes amid a crisis in the medical aid industry (See Page 18). Medical schemes have been hit by excessive claims from members and have been compelled to increase rates.

A number of schemes have indicated they may have to push up membership fees by between 20 and 30 percent.

Sanmed managing director Nick du Preez — who says VAT will only push costs up by eight percent — cautions that increases of this proportion will not only be due to VAT but also to the influx of excessive claims this year.

Medical Association of South Africa chairman Bernard Mandell says the worst pressure will be on patients without medical aid as they would not be able to cope with the increases. Primary health care will also receive a setback. This sector is already surviving on limited resources and its inclusion under VAT would mean funds would have to be diverted from existing services to cater for this, Mandell believes.

"It is a fact that the state is under tremendous pressure to cope with its current load in providing health services. Budgets are being cut and long queues are already becoming a problem," he added.

The Western Cape-based Dispensing Family Practitioners Association (DFPA) has come out strongest against the impositon of VAT on medical services, calling it "immoral".

Chairman Robert Rapiti reckons medical aids are already pricing themselves out of the market and any increases in the rates will put their services out of the reach of ordinary people.

"The government is effectively punishing people for getting sick. That is immoral."

Another group pressing government to zero-rate medical services is the National Medical and Dental Association. Director David Green believes VAT will force people who have been using private health care to start using public health services.

"Only 20 percent of South Africans are on medical aid. This figure is now likely to drop to 15 percent and the five percent will begin using public health services."

Green says this influx into the public sector could be a positive development but "at the moment, our public health service isn't in good shape".

Rapiti says Finance Minister Barend du Plessis told a DFPA delegation in July that "we shouldn't use a moral argument to get medical services exempted because others can do the same with foodstuffs".

Despite all these cries of protest, government is not budging.

The standard rating of health care in this country seems to have been adapted from New Zealand, where everything has a standard VAT rate. South Africa's VAT system is modelled on the New Zealand one. However, in several Western European countries health care is either zero-rated or taxed at a lower rate.

Medical group collects thousands of signatures

By Paula Fray

Thousands of signatures have been collected in a nationwide campaign; opposing VAT being levied on medical services, organised by the Society of Dispensing Family Practitioners.

The petition, launched last month with an advertising campaign, calls for a zero rating on medical services.

The SDFP has described the implementation of VAT on medical services as immoral.

"The Government is imposing a tax on illness when it should be subsidising the cost of illness. We have not got control over when we become ill and accordingly we should not be taxed on medical services and medicines," the petition reads.

SDFP executive member Dr Eddie Sarlie said the petition was going exceptionally well. Between 13 000 and 15 000 signatures from doctors, patients and the public had been returned from the first batch of forms sent out to medical practices.

Forms printed in the press and sent out to individuals were coming in "fast and furiously" and it had been impossible to keep track of the number of signatures.

The society aims to collect a million signatures and present the petition to the Minister of Finance in the first week of September.

Dr Sarlie that with the present economic situation and unemployment rate, there was concern about the affordability of health care.

"The ordinary person can't afford medical treatment at the present time ... how will they afford it with an added 12 percent?" asked Dr Sarlie.

The society was at present on a fund-raising drive among members, he said, and the petition advertising campaign in the media would continue subject to this.

Intensive care facilities short

Neo-natal treatment compromised

ACCEPTED norms for neo-natal intensive care treatment in South Africa need to be critically reassessed because of chronic shortages, Professor Beyers Bresler Hoek warned in Bloemfontein, last week.

He was delivering his inaugural lecture at the University of the Orange Free State, where he is professor and senior specialist of the Department of Pediatrics and Child Health, as well as head of neo-natal services at the city's academic hospitals.

If more facilities and funds were not provided, the number of potential neo-natal intensive care users would have to be drastically curtailed, Hoek predicted.

He acknowledged that much of what he had to say conflicted with traditional and accepted ethics, morals, rights and religious values, but added it was open to critical re-evaluation.

More babies in South Africa needed intensive care treatment than could be handled and the increasing costs - both financial and labour - were difficult to justify.

The provision and maintenance of facilities were expensive and financial resources had not increased proportionately to costs.

Intensive care for certain categories of babies, including premature ones, had to be reconsidered as it was not always in the best interests of the baby, parents or the broader community, he maintained.

As a result of the shortages, more funds would have to be made available from the State, or other sources, to maintain neo-natal intensive care facilities.

Parents would also have to make bigger financial contributions, Hoek said.

Intensive care treatment for babies was a privilege and not a right and he warned doctors would be faced with more difficult "and even impossible" choices.

The present infrastructure to help disabled babies was largely inadequate, he added.

Such babies had a strongly disruptive and even destructive effect on parents, marriages and families.

Parents

Also, the financial implications for the parents and community were enormous.

As for "non-medical guidelines", Hoek said where more than one baby could benefit equally from intensive care, but there was only a facility for one, the following babies should not qualify for intensive care treatment:

Babies whose parents had Aids;

Where one or both parents were addicted to alcohol or drugs;

Those whose parents were permanently unemployed or had no fixed or regular income;

Those who were illegitimate or whose mothers had been raped;

Those whose mothers had received no pre-natal care for reasons other than non-availability or accessibility;

Where both parents were mentally retarded or had major psychiatric disturbances;

Parents had a criminal record;

Parents were guilty of child abuse or molestation;

Parents had three or more healthy children; and,

Parents could not pay at least a portion of the cost for the use of the facility.

Hoek added if a baby did not qualify for intensive care, it did not mean it would receive no treatment.

It would still receive all the necessary care, except treatments particular to intensive care.

The practical settlement of harsh, present-day realities appeared increasingly difficult to reconcile with traditional ethical, moral and religious viewpoints, he said.

According to some economists, the use of scarce and expensive facilities or resources for weak babies was economically unjustifiable.

There were more premature babies in underdeveloped and developing communities than in so-called First World countries, Hoek said.

This, together with the unacceptably high population increase, was an important reason why the number of babies needing intensive care in South Africa was greater than in highly developed countries. - ***Sapa***

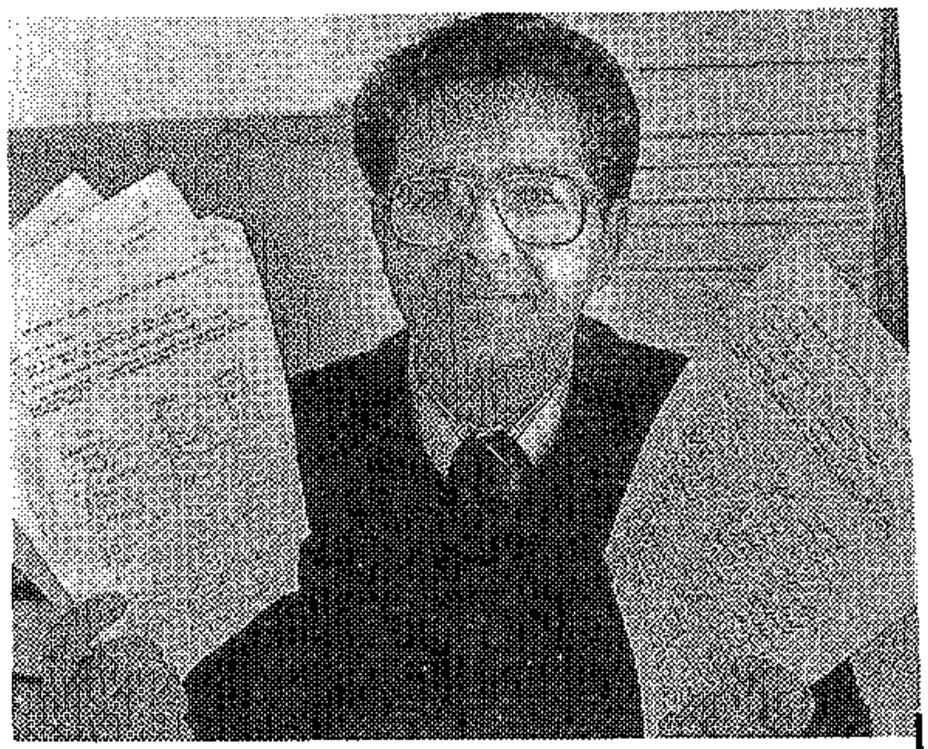
Doctors to apply 'more pressure'

ET 20/8/91 **Staff Reporter**

THE fight against VAT on medical services would continue — even if the Minister of Finance, Mr Barend du Plessis, rejected a Western Cape petition signed by 14 000 people in just three days, doctors said.

The petition, with an initial target of 7 000 signatures, was initiated by the Western Cape Medical Association of SA (Masa). The chairman, Dr Tony Behrman, vowed "more pressure" if the tax on medical services was not scrapped.

Under VAT doctors will pay 12% tax on supplies and recoup it from patients.



ANTI-VAT DOSE . . . Western Cape Masa chairman Dr Tony Behrman has collected 14 000 signatures. Picture: RICHARD BELL

New deal may be known today

Own Correspondent

JOHANNESBURG. — Minister of Finance Mr Barend du Plessis has indicated he might make his VAT announcement today instead of Friday — one day ahead of a VAT summit called tomorrow by the ANC and trade unions. 21/8/91

He is to disclose his proposals at a cabinet meeting this morning.

A statement by the Finance Department yesterday said Mr Du Plessis was unable to reschedule an important meeting on Friday.

Masa delivers VAT petition

A STATEMENT from the Minister of Finance's office is expected later today on a 14 000 signature petition handed to the government by Masa yesterday against the imposition of VAT on medical services.

A spokesman for Pretoria's Medical Association of SA (Masa) confirmed the Masa Western Cape petition had been delivered.

Under VAT, doctors will pay 12% tax on supplies and recoup it from patients. — Sapa

Scores desperate for parts donations

MORE than 1 000 critically ill patients are desperately waiting for kidneys, hearts and livers throughout South Africa, according to Professor John Odell.

Speaking at the launch of Organ Donor Week in Cape Town on Monday, Odell said fewer than 300 transplants were performed annually.

Donors

Odell, chairman of the SA Organ Donor Foundation, attributed the significant drop in organ donor referrals this year partly to the severe cost-saving measures enforced in provincial hospitals.

"The medical profession still has many sceptics with regard to transplantation, particularly now when financial constraints are being considered," he said. - *Sapa*

(d) by the substitution for regulation 28.14.2 of the following regulation:

"28.14.2 An applicant shall not be accepted as a candidate for Part B of the examination unless he has passed part A and he has produced evidence satisfactory to the Commission—

(a) of his sobriety and general good conduct,

(b) that he is the holder of an appropriate blasting certificate recognised by the Government Mining Engineer for the purpose of the examination, and

(c) that he has had at least four years mining experience acceptable to the Commission."; and

(e) by the addition after regulation 28.14.2 of the following regulation:

"28.14.2 (A) An applicant shall not be accepted as a candidate for Part C of the examination unless he has passed Part B and has produced evidence satisfactory to the Commission—

(a) that he has attained the age of 23 years,

(b) of his sobriety and general good conduct,

(c) that he is the holder of a permanent blasting certificate recognised by the Government Mining Engineer for the purpose of the examination,

(d) that, except as is provided for in regulation 28.14.3, he has had at least five years mining experience acceptable to the Commission of which at least four years shall have been gained in the workings of a mine and such experience shall include at least six months at the working face on rock-breaking or winning minerals or work directly connected therewith; and

(e) that he has had at least six months mining experience, acceptable to the Commission, in the workings of the class mine appropriate to the certificate for which he wishes to qualify.".

(d) deur regulasie 28.14.2 deur die volgende regul sie te vervang—

"28.14.2 'n Applikant word nie as kandidaat v Deel B van die eksamen aangeneem nie, tensy h Deel A geslaag het en hy tot tevredenheid van di kommissie bewys gelewer het—

(a) van sy soberheid en algemene goeie gedrag,

(b) dat hy die houer is van 'n geskikte skietsertifikaa wat deur die Staatsmyningenieur vir die doel van di eksamen erken word, en

(c) dat hy minstens vier jaar mynbou-ondervindin tot die tevredenheid van die kommissie gehad het." en

(e) deur die volgende regulasie na regulasie 28.14.2 by te voeg:

"28.14.2 (A) 'n Applikant word nie as kandidaat vi Deel C van die eksamen aangeneem nie, tensy hy Deel B geslaag het en hy tot tevredenheid van die kommissie bewys gelewer het—

(a) dat hy die ouderdom van 23 jaar bereik het,

(b) van sy soberheid en algemene goeie gedrag,

(c) dat hy die houer is van 'n permanente skietsertifikaat wat deur die Staatsmyningenieur vir die doel van die eksamen erken word,

(d) dat hy, behoudens die bepaling van regulasie 28.14.3 minstens vyf jaar mynbou-ondervinding tot tevredenheid van die kommissie gehad het waarvan minstens vier jaar in die delfplekke van 'n myn moet wees en die ondervinding moet minstens ses maande insluit by die werkfront in verband met die breek van rots of die winning van delfstowwe of werk wat regstreeks daarmee in verband staan; en

(e) dat hy minstens ses maande mynbou-ondervinding gehad het, wat vir die kommissie aanneemlik is, in die delfplekke van die klas myn wat toepaslik is op die sertifikaat waarvoor hy hom wil bekwaam.".

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

No. R. 2054 **23 August 1991**

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

REGULATIONS RELATING TO THE QUALIFICATIONS WHICH ENTITLE PSYCHOLOGISTS TO REGISTRATION: AMENDMENT

The Minister of National Health has, in terms of section 24 (1) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), on the recommendation of the South African Medical and Dental Council, made the regulations set out in the Schedule hereto.

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGS ONTWIKKELING

No. R. 2054 **23 Augustus 1991**

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

REGULASIES BETREFFENDE DIE KWALIFIKASIES WAT DIE REG OP REGISTRASIE AS SIELKUNDIGES VERLEEN: WYSIGING

Die Minister van Nasionale Gesondheid het kragtens artikel 24 (1) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), op aanbeveling van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, die regulasies in die Bylae hiervan uiteengesit, uitgevaardig.

SCHEDULE

1. In this Schedule the expression "the Regulations" means the regulations published under Government Notice No. R. 612 of 15 April 1977, as amended by Government Notices Nos. R. 2578 of 23 December 1977, R. 1040 of 26 May 1978, R. 2612 of 29 December 1978, R. 670 of 27 March 1981, R. 1020 of 28 May 1982, R. 1386 of 9 July 1982, R. 2262 of 10 December 1982, R. 1098 of 30 May 1984, R. 1101 of 30 May 1984, R. 1728 of 9 August 1984, R. 89 of 17 January 1986, R. 2162 of 17 October 1986, R. 2595 of 12 December 1986 and R. 1171 of 24 June 1988.

2. Regulation 2 of the Regulations is hereby amended by the insertion of the following qualifications under the applicable heading:

University or examining authority and qualification	*Abbreviation for registration*
Alabama Agricultural and Mechanical University—	
Master of Science in Clinical Psychology	M.Sc. (Clinical Psychology) Alabama Agric. & Mechanical.
University of Amsterdam—	
Doctor of Psychology	Drs. Psychology Amsterdam.
University of Bophuthatswana—	
Master of Social Sciences in Clinical Psychology	M.Soc.Sc. (Clinical Psychology) Bophuthatswana.
Columbia University—	
Master of Arts in Councelling Psychology	M.A. (Counselling Psychology) Columbia.
University of Connecticut—	
Master of Arts in Education	M.A. (Education) Connecticut.
Council of Natal Academic Awards—	
Master of Science in Clinical Psychology	M.Sc. (Clinical Psychology) Council of Nat. Acad. Awards.
University of Delaware—	
Master of Arts in School Psychology	M.A. (School Psychology) Delaware.
Durham University—	
Master of Arts in Guidance and Counselling	M.A. (Guidance and Counselling) Durham.
University of Exeter—	
Master of Ecucation in Educational Psychology	M.Ed. (Education Psychology) Exeter.
Gent University—	
Licentiate in Psychology and Paedagogics	L. (Psychology and Paedagogics) Gent.
Gujarat University—	
Master of Arts in Psychology	M.A (Psychology) Gujarat.
Harvard University—	
Master of Education	M.Ed. Harvard.
Hebrew University of Jerusalem—	
Master of Arts in Social Sciences in Psychology	M.A. Soc.Sc. (Psychology) Hebrew Univ. Jerusalem.
University of Leuven—	
Licentiate in Paedagogics	L. (Paedagogics) Leuven.
Libera Reformata University—	
Diploma in Psychology	Dip. (Psychology) Libera Reformata.

BYLAE

1. In hierdie Bylae beteken die uitdrukking "die Regulasies" die regulasies afgekondig by Goewermentskennisgewing No. R. 612 van 15 April 1977, soos gewysig by Goewermentskennisgewings Nos. R. 2578 van 23 Desember 1977, R. 1040 van 26 Mei 1978, R. 2612 van 29 Desember 1978, R. 670 van 27 Maart 1981, R. 1020 van 28 Mei 1982, R. 1386 van 9 Julie 1982, R. 2262 of 10 Desember 1982, R. 1098 of 30 Mei 1984, R. 1101 van 30 Mei 1984, R. 1728 van 9 Augustus 1984, R. 89 vam 17 Januarie 1986, R. 2162 van 17 Oktober 1986, R. 2595 van 12 Desember 1986 en R. 1171 van 24 Junie 1988.

2. Regulasie 2 van die Regulasies word hierby gewysig deur die byvoeging van die volgende kwalifikasies onder die paslike opskrif:

Universiteit of eksaminerende liggaam en kwalifikasie	*Afkorting vir registrasie*
Alabama Landbou- en Meganiese Universiteit—	
Magister in Natuurwetenskappe in Kliniese Sielkunde	M.Sc (Klin. Sielkunde) Alabama Agric. & Mechanical.
Universiteit van Amsterdam—	
Dokter in Sielkunde	Drs. Sielkunde Amsterdam.
Universiteit van Bophuthatswana—	
Magister in Sosiale Wetenskappe in Kliniese Sielkunde	M.Soc.Sc (Kliniese Sielkunde) Bophuthatswana.
Columbia Universiteit—	
Magister in Lettere en Wysbegeerte in Voorligtingsielkunde	M.A. (Voorligtingsielkunde) Columbia.
Universiteit van Connecticut—	
Magister in Lettere en Wysbegeerte in Opvoedkunde	M.A. (Opvoedkunde) Connecticut.
Council of National Academic Awards—	
Magister in Natuurwetenskappe in Kliniese Sielkunde	M.Sc. (Kliniese Sielkunde) Council of Nat. Acad. Awards.
University van Delaware—	
Magister in Lettere en Wysbegeerte in Skoolsielkunde	M.A. (Skoolsielkunde) Delaware.
Universiteit van Durham—	
Magister in Lettere en Wysbegeerte in Beroepsleiding en -voorligting	M.A. (Beroepsleiding en -voorligting) Durham.
Universiteit van Exeter—	
Magister in Opvoedkunde in Opvoedkundige Sielkunde	M.Ed. (Opvoedkundige Sielkunde) Exeter.
Universiteit van Gent—	
Lisensiaat in Sielkunde en Pedagogiek	L. (Sielkunde en Pedagogiek) Gent.
Universiteit van Gujarat—	
Magister in Lettere en Wysbegeerte in Sielkunde	M.A (Sielkunde) Gujarat.
Harvard Universiteit—	
Magister in Opvoedkunde	M.Ed. Harvard.
Hebreeuse Universiteit van Jerusalem—	
Magister in Lettere en Wysbegeerte in Sosiale Wetenskappe in Sielkunde	M.A. Soc.Sc. (Sielkunde) Hebreeuse Univ. Jerusalem.
Universleit van Leuven—	
Lisensiaat in Pedagogiek	L. (Pedagogiek) Leuven.
Libera Reformata Universiteit—	
Diploma in Sielkunde	Dip. (Sielkunde) Libera Reformata.

University of London—	
Master of Science in Child Development	M.Sc. (Child Development) London.
University of Massachusetts—	
Master of Eduction.....	M.Ed. Massachusetts.
University of Natal—	
Master of Arts in Educational Psychology	M.A. (Educational Psychology) Natal.
Master of Science in Educational Psychology	M.Sc. (Educational Psychology) Natal.
Master of Social Sciences in Educational Psychology	M.Soc.Sc. (Educational Psychology) Natal.
University of Nottingham—	
Master of Arts in Child Psychology..	M.A. (Child Psychology) Nottingham.
Paris X Nanterre—	
Master of Arts in Psychology.....	M.A. (Psychology) Paris X Nanterre.
Rand Afrikaans University—	
Master of Arts in Human Resource Management	M.A. (Human Resource Management) RAU.
Master of Commerce in Human Resource Management	M. Com. (Human Resource Management) RAU.
University of South Africa—	
Master of Arts in Industrial Psychology	M.A. (Industrial Psychology) South Africa.
Master of Arts in Research Psychology	M.A. (Research Psychology) South Africa.
Tufts University—	
Master of Education in Counselling.	M.Ed. (Counselling) Tufts.
Wright Institute—	
Master of Arts in Psychology.....	M.A. (Psychology) Wright Institute.

No. R. 2055 **23 August 1991**

FOODSTUFFS, COSMETICS AND DISINFECTANTS ACT, 1972 (ACT No. 54 OF 1972)

ENFORCEMENT BY LOCAL AUTHORITIES

I, Elizabeth Hendrina Venter, Minister of National Health, hereby authorise under section 23 (1) of the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972), the undermentioned local authorities to enforce the relevant provisions of the said Act within their respective areas of jurisdiction and through their duly authorised officers:

Municipality of Allanridge.

Municipality of Hoopstad.

Municipality of Wesselsbron.

E. H. VENTER,

Minister of National Health.

Universiteit van Londen—	
Magister in Natuurwetenskappe in Kinderontwikkeling	M.Sc. (Kinderontwikkeling) Londen.
Universiteit van Massachusetts—	
Magister in Opvoedkunde.....	M.Ed. Massachusetts.
Universiteit van Natal—	
Magister in Lettere en Wysbegeerte in Opvoedkundige Sielkunde	M.A. (Opvoedk. Sielkunde) Natal.
Magister in Natuurwetenskappe in Opvoedkundige Sielkunde	M.Sc. (Opvoedk. Sielkunde) Natal.
Magister in Sosiale Wetenskappe in Opvoedkundige Sielkunde	M.Soc.Sc. (Opvoedk. Sielkunde) Natal.
Universiteit van Nottingham—	
Magister in Lettere en Wysbegeerte in Kindersielkunde	M.A. (Kindersielkunde) Nottingham.
Paris X Nanterre—	
Magister in Lettere en Wysbegeerte in Sielkunde	M.A. (Sielkunde) Paris X Nanterre.
Randse Afrikaanse Universiteit—	
Magister in Lettere en Wysbegeerte in Menslike Hulpbronbestuur	M.A. (Menslike Hulpbronbestuur) RAU.
Magister in Ekonomiese en Bestuurs wetenskappe in Menslike Hulpbronbestuur	M. Com. (Menslike Hulpbronbestuur) RAU.
Universiteit van Suid-Afrika—	
Magister in Lettere en Wysbegeerte in Bedryfsielkunde	M.A. (Bedryfsielkunde) Suid-Afrika.
Magister in Lettere en Wysbegeerte in Navorsingsielkunde	M.A. (Navorsingsielkunde) Suid-Afrika.
Tufts Universiteit—	
Magister in Opvoedkunde in Voorligting	M.Ed. (Voorligting) Tufts.
Wright Instituut—	
Magister in Lettere en Wysbegeerte in Sielkunde	M.A. (Sielkunde) Wright Instituut.

No. R. 2055 **23 Augustus 1991**

WET OP VOEDINGSMIDDELS, SKOONHEIDSMIDDELS EN ONTSMETTINGSMIDDELS, 1972 (WET No. 54 VAN 1972)

TOEPASSING DEUR PLAASLIKE BESTURE

Ek, Elizabeth Hendrina Venter, Minister van Nasionale Gesondheid, magtig hierby kragtens artikel 23 (1) van die Wet op Voedingsmiddels, Skoonheidsmiddels en Ontsmettingsmiddels, 1972 (Wet No. 54 van 1972), ondergenoemde plaaslike besture om binne hul onderskeie regsgebiede en deur middel van hul behoorlik gemagtigde beamptes die toepaslike bepalings van genoemde Wet uit te voer:

Munisipaliteit van Allanridge.

Munisipaliteit van Hoopstad.

Munisipaliteit van Wesselsbron.

E. H. VENTER,

Minister van Nasionale Gesondheid.

alive in a hostile world.

removing unnecessary constraints.

tra-regional trade. — Sapa.

Call for consolidation of health services

B Diary 26/8/91.

GERALD REILLY

PRETORIA — Health services had to be consolidated as far as possible within the limitations of the present constitution, National Health director-general Coen Slabber said at the weekend.

Speaking at a meeting of the United Municipal Executive in Uvongo, Natal, Slabber said Cabinet had decided all primary health care services should be provided by local authorities.

Increasing criticism of the present system had necessitated its restructuring.

This included too many authorities involved in the same functions inside the same geographical region.Services were also not accessible to all.

"We cannot afford the existing duplication of services. One authority must take full responsibility for a specific service within a defined geographical region."

Slabber said further negotiations on the issue were needed.

It could take five years to complete the implementation of the policy.

The transfer of functions had to be accompanied by a transfer of personnel and funds. This did not mean government would scale down its involvement in health services, he said.

PEANUTS By Charles Schulz

Teachers' body formed

AN association representing teaching groups with a membership of more than 100 000 was founded on Saturday at a meeting in Johannesburg.

The National Professional Teachers' Organisation of SA (Naptosa) incorporates 12 teaching bodies with, as vice-president John Stonier said, very disparate views into one umbrella body which would ensure that the interests of the child would not be harmed. B Diary 26/8/91

Among others, the organiation is committed to non-racialism and political non-alignment.

Stressing that Naptosa was not set up in opposition to the SA Teachers' Union, president Leepile Taunyane said his organisation differed in methods of dealing with educational issues. — Sapa.

25 years for racist killing

B Diary 26/8/91

SUSAN RUSSELL

TWO Newlands men who murdered a disabled black passerby by kicking him to death before putting a tyre over his body and setting it alight were sentenced to 25 years imprisonment each in the Rand Supreme Court on Friday.

Sentencing Deon Frederik van Deventer and Evert Boonzaaier, Mr Justice Joffe said the only reason the pair had murdered Johannes Masango was because he was black and had happened along the same time as they had.

Attacked

In judgment earlier last week Mr Justice Joffe, sitting with two assessors, found that the pair had the direct intention of killing Masango.

Masango and his friend Philemon Motimona were walking home after buying some food on the night of September 14 last year when they were attacked by Van Deventer and Boonzaaier.

Motimona managed to run away but Masango handicapped by an old foot injury, was assaulted by the two men.

Van Deventer and Boonzaaier repeatedly kicked Masango who fell to the ground. After pouring beer on him and urinating on him they threw his body on to the back of a bakkie. They offloaded the body near Newclare station where they put a tyre over him and set it alight.

State counsel Danie Dorfling asked the judge to impose the death sentence.

Mr Justice Joffe said mitigating factors included the fact that the murder had not been pre-meditated and both had been under the influence of strong drink and drugs.

Among the aggravating factors was that both men had elected not to take the court into their confidence and testify about what had happened that night.

Both men also showed no remorse, the judge said, and the attack on Masango had been unprovoked and prolonged.

They had also shown no respect for Masango's body by burning it.

"They went to the Belmont Hotel after this gruesome attack," the judge said, "with their hands and clothes smeared with blood."

Van Deventer then told an aquaintance they had "killed a kaffir, put a tyre over him and burnt him".

'Drip deaths' saga

(85)
CT 26/8/91

Lawyer slams inquiry into 15 fatalities

JOHANNESBURG. — A lawyer has charged that wrong and unnecessary judicial procedures have been used to investigate deaths linked to suspected contaminated pharmaceuticals at three Reef clinics last year.

Mr Peter Soller represents 15 families of babies and adults who died or experienced serious side-effects after allegedly contracting klepsiella bacterial infections from intravenous infusions between February and September last year.

More than a year was wasted by referring the matter to the attorney-general of the Witwatersrand, instead of immediately appointing a commission of inquiry as the families requested, Mr Soller said in letters to Justice Minister Mr Kobie Coetsee, which were released to Sapa last week.

After more than 18 months there was still no clue as to when, where and if a promised inquest would take place, he said.

Meanwhile, some parents had emigrated in mistrust of local medical standards, families were breaking up due to the emotional trauma, and important evidence was being lost as time faded detailed recollections, Mr Soller said.

He called on Mr Coetsee to convene a properly constituted tribunal within three weeks headed by a judge or magistrate assisted by professional assessors .

Transvaal regional magistrate Mr T J la Grange was appointed by Mr Coetsee on July 18 to conduct an inquest into the deaths of 13 infants following the completion of investigations by the attorney general's office and the police.

Mr La Grange said at the weekend that he had not yet set a date for the inquest as his own investigations were still continuing.

Attorney-General Mr Klaus von Lieres said: "Each single case in which death occurred, which was brought to my attention, and which falls within my jurisdiction and was linked to intravenous drips, has been investigated."

Out of the 54 cases presented to him, he had found that 13 qualified for investigations in terms of the Inquest Act, Mr Von Lieres said.

He added that the investigations of his staff had been completed in less than six months and he doubted that a commission of inquiry would have been able to move any faster. — Sapa

School health nurses battle against odds

By GRACE RAPHOLO

SCHOOL health services are fundamental to the health of the nation and they form an integral part of the primary health programme.

This was said by a community health specialist, Dr Frans Maluleke, during the Soshanguve School Health Services 10th anniversary celebrations last week.

He said the school health services were disrupted during school riots, vacations and examination. These interfered with the smooth functioning of the service and they prevented the nurses from carrying out proper assessments of the pupils' health.

A community health nurse, Mrs Bongekile Tshazibane, said the school health service programme was "challenging, demanding and finally rewarding."

At present the school health services serve 10 high and 26 primary schools in Soshanguve. It also has 105 childminding staffers involved in the programme and they receive continuous intensive training from the Community Health Department at Medunsa.

Tshazibane said children in primary school were screened for any physical defects or illnesses while high school pupils were referred by teachers. High school pupils were also at liberty to contact the nurses about any personal problems they might have.

Outlining some of the problems they had to work under, Tshazibane said they had to talk to the community about common physical defects detected in the pupils.

●Parents were also not available during the day - a time when the nurses were on duty.

Health spending injection queried

By Carina le Grange

Health bodies last night welcomed the R84 million the Government has allocated to health services in announcing an aid package of R1 billion but was critical about the way the money is to be used.

The National Medical and Dental Association (Namda) and the SA Health Workers Congress (SAHWCO) both questioned whether the building of 141 new clinics would be the best way to spend the money in view of staff shortages.

Dr David Green of Namda said: "It would be hard not to welcome the relief, but the way in which it is spent should be decided after consultation with communities.

"Is there staff for clinics? Capital expenditure may not be what is needed at the moment.

Dr Green also said lower-paid workers, who would be hardest hit by the introduction of VAT on basic foodstuffs, would not benefit from the relief.

Dr Aslam Dasoo of SAHWCO said any attempt to improve social services was welcomed.

"This is unfortunately, however, fundamentally flawed, as extensive research has indicated that the deficiencies in health services are not structural — the major problem is a lack of staff. What is urgently needed is an injection of funds into the training of health personnel, or we will have clinics but no staff."

Kane-Berman is top businesswoman

TANIA LEVY

GROOTE Schuur Hospital regional chief superintendent Dr Jocelyne Kane-Berman was named Businesswoman of the Year at a banquet in Johannesburg last night.

This is the first time someone from the public sector has won the award, presented annually by the Executive Women's Club of Southern Africa.

Kane-Berman was the centre of controversy in 1988 when she was transferred from her post as the hospital's medical superintendent after suggesting that the Cabinet be replaced by a government headed by then jailed ANC leader Nelson Mandela.

She was reinstated in March 1989 after an outcry from colleagues and leading figures in the medical profession.

Businesswoman of the Year judging panel chairman Goldfields chairman Robin Plumridge said Kane-Berman was the country's most outstanding hospital administrator. She represented an outstanding role model not only for women, but for all managers in the public sector.

"Running a major hospital complex is a massive task that would tax anyone's management capability," he said.

Kane-Berman is responsible for medical services in the region which extends from Cape Town as far east as George.

Despite cuts in health budgets just two months before the financial year-end, Kane-Berman managed to reduce expected expenditure by R4m without a drop in the quality of the hospital service and she helped to raise R2,7m for radiotherapy equipment for the hospital.

Fabcos executive Dora Ndaba, Simba Group finance director Trix Coetzer and Topics Stores merchandise director Erica Roodt were finalists.

● Picture: Page 3
● See Page 10

Masa: VAT not breaking rules

Star 6/9/91

By Carina le Grange
Medical Reporter

The collection of VAT from patients would not be in contravention of rules of the South African Medical and Dental Council (SAMDC) which state that a doctor may not share his fee with any person who had not taken part in the services, the Medical Association of South Africa (Masa) said yesterday.

In a letter published in The Star yesterday, Dr S Flax of Malvern said he believed that any medical practitioner charging VAT for services, and then sharing the fee with the Minister of Finance, would be contravening SAMDC rules.

Sharing fees

He referred to a Government notice referring to rules specifying "acts or omissions in respect of which the council may take disciplinary steps" which included "sharing fees".

Dr Flax said that from this it was clear to him that Minister Barend du Plessis was ordering him to act unethically.

Masa secretary-general Dr Hendrik Hanekom said it fully supported the principle that VAT should not be collected on medical services, and that it identified and had empathy with doctors who had difficulty with the principle of collecting VAT from patients.

Masa could not, however, not "support the argument that this would amount to unethical behaviour".

"Doctors are not sharing fees; they are adding value on to their fees in terms of the provisions of the Value Added Tax Act, and collecting this on behalf of the Receiver of Revenue ... VAT is viewed in terms of the Act as an amount over and above the fee charged for services rendered," Dr Hanekom said.

It would not be illegal or unethical, the body said.

National Medical and Dental Association national director Dr David Green said Namda agreed with the sentiments regarding the ethics of taxing medical services and that it believed there were strong moral arguments against it.

"However, the legal situation ... is complex and relatively contentious. Can VAT on a doctor's bill be construed as part of the fee?" Dr Green asked.

The Department of National Health, the SAMDC and Namda are expected to respond to the issue today.

JOCELYNE KANE-BERMAN

Business at the bedside

FM 6|9|91

"Hospitals are a big business," says Jocelyne Kane-Berman when asked why the Executive Women's Club would bestow its Businesswoman of the Year award on a medical manager. "We're not in it for a profit, but we have to use all our resources effectively and efficiently and with high productivity. I think that's business."

As chief medical superintendent of the Groote Schuur Hospital Region, which stretches from Cape Town to George, Kane-Berman (58) oversees a R357m budget. Testing her administrative abilities has been the 15% budget cut this year for Cape health services. She admits it is agonising.

"We are tremendously proud of Groote

Kane-Berman ... *mixing medicine and business*

Schuur and the other hospitals in the region. To damage or destroy what's been built up over a long time is difficult and stressful. People get demoralised. Trying to maintain morale is one of my major tasks."

She sees "some form of national health service" and increased taxes as just about inevitable under a future government. She also sees an "enormously unexpressed need" coming from rural people who move to the city and quickly realise they can get health care for their children and themselves. "That is going to erupt on us like a volcano."

Kane-Berman's father, a Johannesburg dentist, urged her to study medicine and her teenaged desire to save the world made it easy to go along with his wish. Her love of children pointed her towards paediatrics at the University of Cape Town. The day after graduation, she married Bill Ritchie, an architecture student. Since then, she has retained a love for design, including four years spent planning the new Groote Schuur.

She also retained her maiden name. "I'm happy to be a Kane-Berman," she says, ticking off some illustrious relations (including cousin John, who heads the Institute of Race Relations; uncle Louis, who led the Torch Commando; and a grandmother who was Chief Commandant of the Red Cross).

While her four children were young, she worked part-time in clinics and schools, but, in 1970, she tried her hand at medical administration and loved it. She went on to earn a Master's in public administration.

"I'm not a yeller and screamer," she says of her management style. "I would much rather work with a team. But clearly, one has to be autocratic sometimes. A hospital cannot always be a democracy."

She's very concerned about the flight of young doctors out of the country. "They may have to be coerced into staying if they cannot be persuaded. They can't take and not give in return — thinking the world owes them a living." And she doesn't limit her tough talk to interns. "Doctors need to be humble. We need to come off our pedestals. In fact, society is already knocking us off our pedestals." ■

Health crisis spelt out to government

(85) AEG 10/9/91

The Argus Correspondent

JOHANNESBURG. — Big business has warned the government health care problems have reached crisis levels, and urged sweeping action to abolish stubborn remnants of apartheid in medical services.

The South African Chamber of Business (Sacob) wants urgent talks with National Health Minister Dr Rina Venter over the crisis.

It said in a special report segregation was still practiced in hospitals, and government had left too many loopholes to ensure real integration.

And Dr Mike Baker, one of the authors, warned that medical aid costs looked set to bound at least 25 percent higher this year as private sector health services became more and more expensive and public sector services showed still more marked deterioration.

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'Merge health ministries'

TANIA LEVY

SA CANNOT afford to double its health spending to give all races the kind of private health care enjoyed by whites, Sacob says in a new position paper.

Sacob's personnel practices and social policy committee lays blame for much of the health crisis "squarely" at government's door.

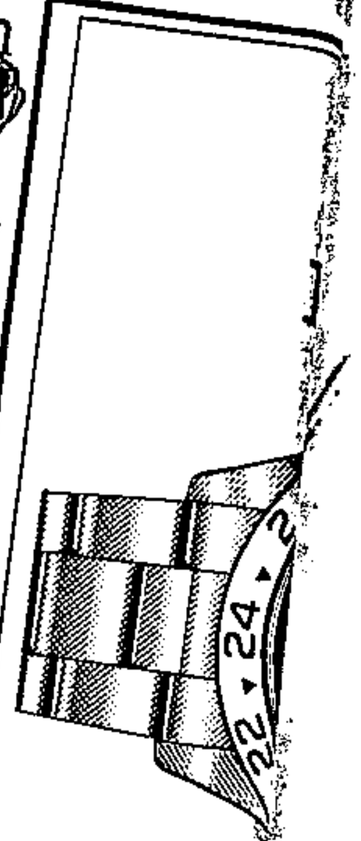
It calls for the merging of health ministries.

It adds that the response of the public and private sectors to the health crisis has been disappointing.

The National Health Department seems intent on privatisation, while the private sector has looked after its own economic interests, it says.

The paper says government is interested in health privatisation for the wrong reasons: unburdening itself of rising costs and transferring them to the private sector and individuals.

Privatisation of provincial hospitals would further increase the cost of hospital care and lead to a decline in its quality and availability.



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Call for single body on health

Own Correspondent

JOHANNESBURG. — South Africa cannot afford to double its health spending to give all races the kind of private health care enjoyed by whites, the SA Chamber of Business says in a new position paper.

Sacob's personnel practices and social policy committee lays blame for much of the health crisis "squarely at the door of the government and the National Health Department".

The paper, which has been forwarded to Minister of National Health Dr Rina Venter, says the different health ministries should urgently be disbanded and merged into a single health department.

It adds that the response of the public and private sectors to the health crisis has been disappointing.

Wrong reasons

The National Health Department seems intent on privatisation, while the private sector has looked after its own economic interests, it says.

The government, the paper says, is interested in health privatisation for the wrong reasons — to unburden itself of escalating costs and transfer them to the private sector and individuals.

But privatisation on a wide scale would further increase the cost of hospital care and lead to a decline in its quality and availability.

About 80% of the population depends on public-sector health provision, the paper says.

Only about 6% of the black population belongs to a private medical aid, compared to about 70% of whites.

Diarrhoea: Killer of SA children

(86) CT 11/9/91

By BARRY STREEK

THOUSANDS of South African children die because of diarrhoea, and the disease causes 20% of the deaths of children under four, the Minister of National Health, Dr Rina Venter, said last night.

During 1988, 6 693 deaths attributable to diarrhoea were recorded in the age group of four years or younger, and this represented 20% of all deaths in that age group, she said in a statement.

Dr Venter also announced the launch of an intensive educational programme and a new co-ordinated national strategy for the prevention of diarrhoea.

Diarrhoea and its accompanying dehydration is one of the biggest causes of disease and death in developing countries.

Health care

More than 3,5 million children under the age of five died worldwide every year as a result of diarrhoea.

Dr Venter said research had shown that many of these deaths could be prevented with the use of a simple and economical oral-rehydration therapy (ORT), consisting of the administering of a solution of salt and sugar in water.

"This year we will pay increased attention to ORT as part of the countrywide primary health-care programme.

"This forms part of the change in emphasis in preventive treatment and the promotion of better health habits."

Special emphasis was placed on immunisation against measles as the promotion of primary health care in 1990.

"As a result, hundreds of lives were saved," Dr Venter said.

doctor ordered?

Just what the do

A change of heart is on cards for medics in new SA

S/Times 15/9/91.

MEDICAL schools have been asked to submit proposals to the South African Medical and Dental Council for a planned "reform" of qualifying courses for student doctors.

But medical professors say a revamp of the curriculum would not lower standards. Instead, it would better equip doctors for the new South Africa.

SAMDC registrar Nico Prinsloo said: "In the light of changing demands on doctors' ability to treat their patients, and because of new developments in medicine in recent years, the council decided to call for proposals which review existing curriculums for medical students.

"It's not a specific request to make changes," he said, "but a request to decide whether change is necessary."

By EVELYN HOLTZHAUSEN

The last review was carried out over a decade ago, although there is continuing discussion between the medical schools and the education committee of the SAMDC, on which a number of medical school deans sit.

All doctors practising in SA have to pass examinations approved by the council, to which they are then registered.

Medical schools are paid regular visits by council "inspectors" to ensure standards are maintained.

Needs

According to Mr Prinsloo, the planned review is not intended to lower standards — just the opposite.

"We want to ensure student doctors are better qualified to meet the particular needs of their patients," he said.

"It's got to do with the role a doctor plays in society and the qualifications he needs to best be able to play that role," said Mr Prinsloo.

According to Professor Alan Rothberg, deputy dean of the University of the Witwatersrand Medical School, the council allows each medical school some leeway in which the prescribed curriculum is applied.

He said a new curriculum had been introduced for first-year students at Wits three years ago.

Under the system, student doctors have to study a minimum "core" of prescribed essential subjects.

In addition to these they can choose from a wide variety of elective subjects, including an African language, human behavioural sciences, molecular biology, medical ethics and community health.

"This will better qualify them for the fields in which they intend to work and allow them to be more attuned to their particular area of interest," said Professor Rothberg.

Professor Graham Mitchell, who oversees the curriculums of Wits Medical School students, said that the minimum core of approved subjects included the legal requirements for students to qualify at the same previous standard.

"But, by cutting back on non-essential detail of studies in some fields, a student can create the time to learn a subject which could be of real benefit to his patients."

He cited an example of a student doctor who intended to practise in a rural area.

Study

Instead of a student spending five hours a week studying the detail of nasal nerves, he might spend the minimum of two hours.

"He then has three 'spare' hours in which to study an African language he will need to treat rural patients, or some other subject he believes will be of benefit to him," said Professor Mitchell.

"It does not mean he is less qualified as a doctor. What it means is that his education is more rounded, enabling him to better apply what he has learned."

Professor Mitchell said the curriculum of each student was customised to suit his needs.

"There is no standard curriculum for each student, but a first-year student has to do a full compulsory year of biology. In addition, he can decide to do a full course in physics and a full year of chemistry.

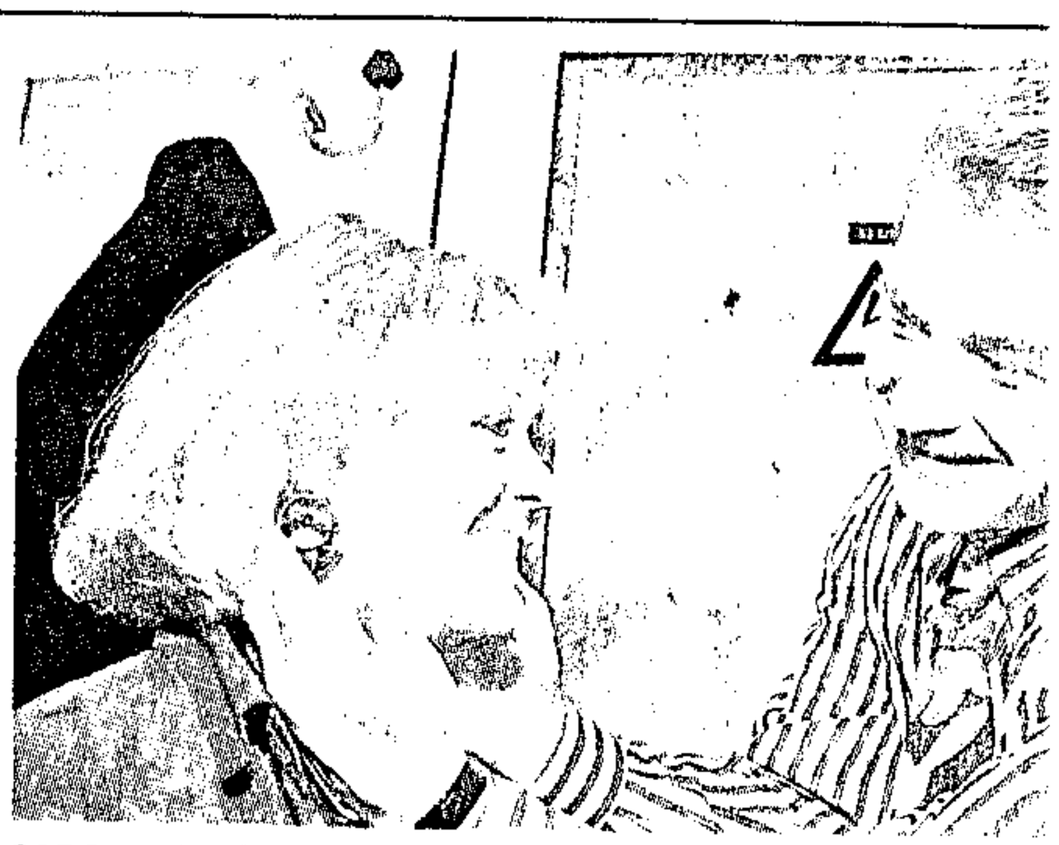
"Or he can do a core course in physics and a core course in chemistry, which will leave him time to study human behavioural science, bio-medical mathematics or Zulu.

"But he is free to do a full course in physics and chemistry and none of the others if he so chooses.

"In second year, all students have to do anatomy and physiology. They can then add core courses in biology or any of the 13 other courses available."

He said all students would still have to do full courses in the essential subjects.

"The concept of the core courses enables the students to make better use of their time while not losing any knowledge of the essentials," he said.



SABC stylist Claudio Incontri puts the finishing touches to

Sunday Times Reporter

THE familiar blonde locks of TV1 newscaster Ellen Erasmus took on a new shape this week. Gone is the teased-up look. In comes a fringe.

"I decided it was about time I had a change," explained Ellen. "Perhaps it has something to do with the fact that spring has arrived."

The new look, a modified page-boy which exploits Ellen's natural curls, was created by Claudio Incontri, one of the SABC's top stylists. It drew approving comments from viewers when Ellen first showed it on Tuesday night.

Ellen, 31, who plans to marry 42-year-old Klerksdorp businessman Ralph Morton next year, has another reason to feel perky — she and Ralph leave for a three-week holiday in Europe at the end of the month.

"I'm really looking forward to it," said Ellen. "We're going to Rome, Paris, London and Lisbon, in that order. It's very romantic."

This will be Ellen's first real trip overseas, even though she was a diplomatic baby, born in London.

It will also be the longest time she has spent away from the SABC. "How will I cope without them? As well as they'll cope without me," she laughed.

Her the abo Elle new styl

Home— for just a day

S/Times 15/9/91

By EVELYN HOLTZHAUSEN

TODAY, for the first time in 14 years, the Mfengu people are going "home".

But it will be for one day only — and they will be defying a government order.

The leader of the displaced tribesmen, Tsitsikamma Exile Association co-ordinator Mashwabada Msizi, said the return was "deeply symbolic".

A commemorative service will mark the day in 1977 that former State President PW Botha signed an eviction order banishing the 500-strong Mfengu community to the Ciskei.

The tribe was granted 8 000 hectares of fertile coastal farmland by Queen Victoria in 1837. Now 6 000 hectares of the land is in the hands of 19 white farmers, who bought it from the government in 1983.

Mr Msizi said he was confident that by Christmas about 50 Mfengu families would be permanently settled on land adjacent to that from which they were evicted. The land is owned by the Moravian Church.

The chairman of the Board of the Moravian Church of South Africa, Mr Martin Wessels, confirmed that negotiations were taking place to move the families on to the land.

He said the land was given to the church in trust for the Mfengus "in perpetuity". It had to be established if the deeds for the land could be legally handed over to the tribesmen.

In papers lodged in the South Eastern Cape Division of the Supreme Court on May 7, 14 Mfengu community leaders demanded that the SA Development Trust and 22 others — including the 19 farmers — return the land to them.

They asked the court to expunge the name of the state from the title deeds of other farms on "their" land.

Mo

JACI Fran

Small-town churchmen: Homoeopathy 'not of God'

(85) CT 16/9/91

Own Correspondent

QUEENSTOWN. — Thirteen Queenstown and Tarkastad clergymen have warned against the practice of homoeopathy.

They stated in a letter to the weekly Queenstown Representative that the homoeopath consulted "other" forces. Such practices, they claimed, would have a negative rather than a positive influence over the patient in the long term, were spiritual and not of God and should therefore be avoided.

The warning came after a speech here on Thursday night by East London homoeopath Mrs Ann Botha.

Organisers of the speech claimed some resistance to ticket sales on the grounds that the clergy had warned against evil forces. However, 170 tickets were sold and as ticketholders arrived at the town hall they were met by a small group of people praying against "such forces at work inside".

The audience listened to Mrs Botha, who has practised homoeopathy for 26 years after qualifying as a nursing sister in London, tell them health was not a privilege but a duty, and to keep their mind, body and spirit healthy as the ultimate aim in life was to become one with their Creator.

Comment from the audience after the meeting was positive. One man said he could not associate anything in Mrs Botha's talk with satanism, and suggested ignorance had much to do with rumours of this nature.

Another felt the speaker was honest and open with nothing to hide.

"She talks sense and gives reasons for what she says. If homoeopathy could not help diseases like diabetes, she said so."

As for the group praying on the Town Hall steps, many in the audience felt they should have listened to the talk, then judged the speaker.

Asked yesterday to comment on the letter, an amazed Mrs Botha said she was sorry people who claimed to teach religion and Christianity were so "narrow-minded, dogmatic and blind".

She said homoeopathy totally followed the Christian faith and was not subjected to medieval superstitions or to superstitious ignorance.

A NO-FRILLS OPERATION

Argus Sep. 1991

IF management heaven is built on a small, no-frills operation, led from out front, where everybody is imbued with the company mission and nobody works for the money, then the Independent Development Trust may be staking some claim to immortality.

In size and style, the IDT shows many of the best features of private sector management, and appears to avoid the sort of waste and excess so often associated with NGOs (non-governmental organisations).

There are no pictures on the walls of the Trust's staff headquarters at the Rozenhof office complex in Kloof Street, Cape Town. It's all quite plain and practical. Everyone sitting down is surrounded by piles of paperwork and everyone standing up is going directly from one place to the next. Everyone is back from lunch at 2pm sharp. And if you want an appointment or an answer, you can get one — quickly.

The nearby headquarters at 14 Keerom Street, an old Cape Dutch townhouse, is more attractive but the atmosphere, charged by the physical presence and vigour of Jan Steyn himself, is every bit as intense and focused as Kloof Street.

Steyn was determined that the IDT's size and style should reflect its mission — a major assault on poverty. Thus all its operations are run economically and the IDT itself remains small. Countrywide, from Steyn to the tea lady, the IDT has 29 full-time staffers including four in the Transvaal and two in Natal. It is not expected to grow beyond 35.

Of the IDT's R2 billion in funds, it spends only R10 million — or 1c in every R20 — to pay salaries, run the office and retain outside help in managing the funds.

The IDT has 15 trustees, including Steyn. He is also chairman of the executive committee of eight people, which reports to the trustees.

Assembling this team was Steyn's first task. "I was looking," he says, "firstly for concerned South Africans with a track record in development work, or who, whether by their academic or practical performances had demonstrated a capacity to contribute.

"They had to be people I knew and trusted, who were prepared to come, not on the basis of looking for a career, but to make a contribution in the short and medium terms.

"Secondly, the group — both trustees and executives — had to be broadly representative of the various threads of the tapestry of the South African populace.

"It's nonsense, by the way, to suggest I was looking for people representing the ANC or the PAC or Inkatha or the like. You can draw whatever inferences may be necessary simply from individuals' various and contrasting backgrounds and experiences."

Thus the trustees and directors generally have access to a wide range of leaders in politics and business, but each one also brings to the Trust special knowledge and experience which are important to its job as a development catalyst.

This makes for a dynamic mix, says communications director Jolyon Nuttall. "It's as if all these talents have a multiplier effect on each other. Extraordinary energy is released. The whole is far greater than the sum of its parts."

You can see that process at work at a typical Monday morning meeting of the executive committee. The agenda is long, lunch is short, discussion is brisk.

These proceedings, and the operation as a whole, are permeated by a sense of mission. Says Nuttall: "No one does it for the money. There's an excitement, a nervousness even, an awareness that this is an opportunity which cannot be let slip."

95

THE NEW FACES

ENOS Mabuza, left, above, former chief minister of KaNgwane, and Professor Wiseman Nkuhlu, principal of the University of Transkei, have agreed to join the IDT as executive directors.

Their appointments mean there are now eight members of the executive committee.

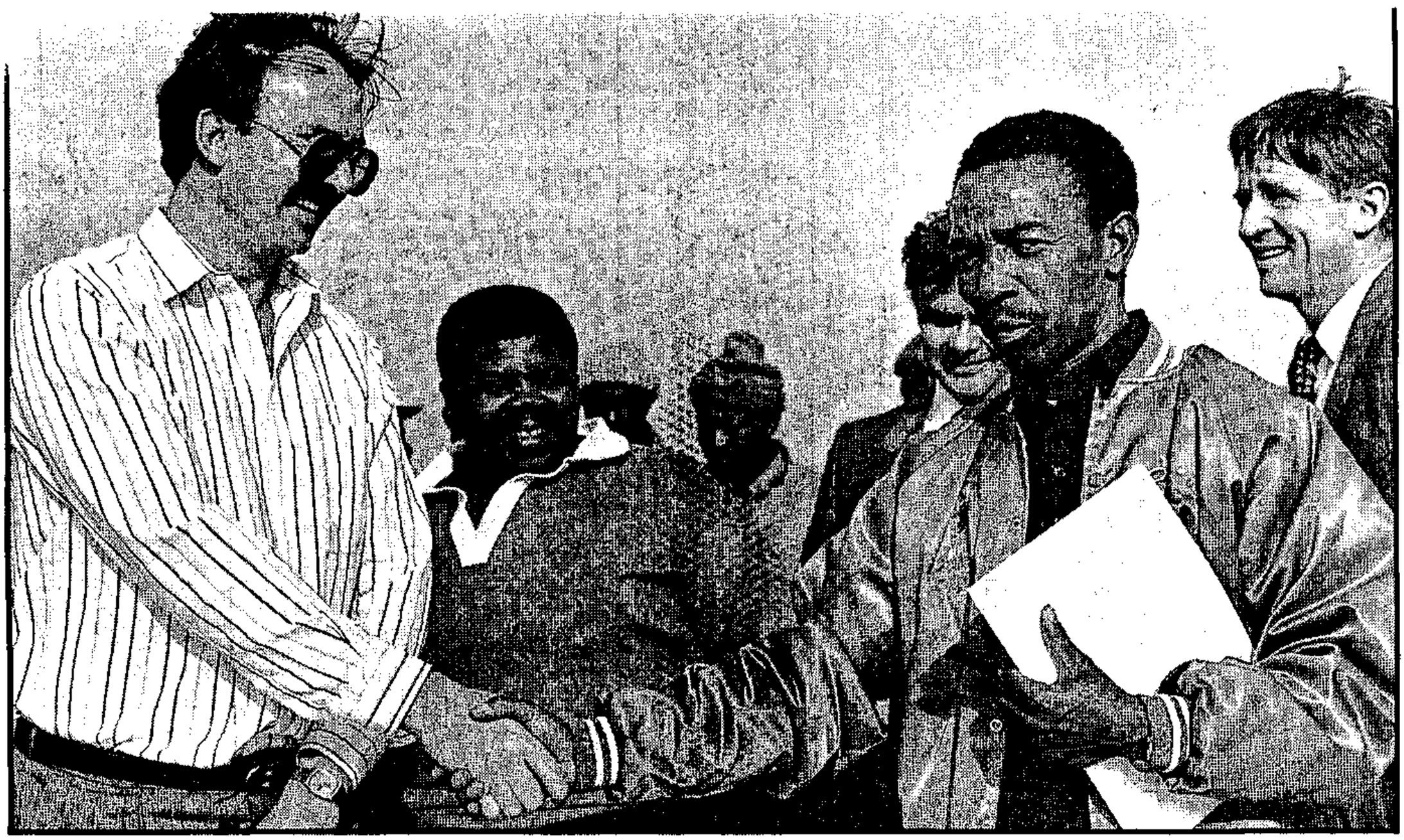
Mabuza stepped down as chief minister earlier this year and now serves as a director of several large companies. He started with the IDT in August and is working from its Johannesburg office.

He will play an important part in the IDT's top-level negotiations, and in its programme of communication with groups and organisations.

Prof Nkuhlu is already an IDT trustee. From January 1, 1992, however, he will use a year of sabbatical leave from the University of Transkei, to take up a job as Executive Director: Project Development for the IDT.

He will be working in two of the IDT's main areas of operation, education and health. In education, his main job will be to plan a national programme to set up community learning centres. An important part of this will be the setting up community trusts to run the centres.

In the health area, Nkuhlu will be working on a national programme for building clinics. This programme, and the clinics, will be linked to the IDT's project for building schools.



☐ Chris Dhlamini, CAST and COSATU, right, congratulates the developer, Johan Walters, Citicom, at the Etwatwa Learning Centre, at Emaphupheni, near Daveyton on the East Rand — the first school to be built under the IDT's National School Building Initiative. A feature of the new school is its "two-of-everything" approach — two headmasters, two sets of teachers and two "schools" of pupils will share the main buildings. The broader community will also use the school hall, which has been built across the road from the learning centre. Standing behind Dhlamini are Prof Merlyn Mehl, IDT education director, left, and Denis Creighton, the PERM.

Breaking the cycle of poverty

THE Independent Development Trust has earmarked nearly R1,5-billion, or 75 percent of the money entrusted to it by South African taxpayers in 1990, for development projects for the poor.

The IDT aims to help South Africa's poorest citizens break the cycle of poverty, and is attacking backlogs in housing, education, health, and community and rural development.

Of the R2-billion transferred by government to the IDT's account via treasury bills and government stock last July, R1 476 million was set aside for about 150 projects in the IDT's first year of operations, which ended on July 31, 1991.

Among the major items were:

☐ R750-million to a capital subsidy scheme for the development of nearly 100 000 sites, to accommodate abut 700 000 people;

☐ R300-million to the building of 50 000 new classrooms to serve as learning centres for various sectors of the community;

☐ R70-million to set up a majof pre-school educare programme for under-privileged children; and

☐ R47-million to create a finance house for home loans for people who are too poor to borrow from building and banks in the usual way.

☐ R12,6-million to an AIDS education and health care network.

Although large sums of money have been made available, the IDT is very careful about how it spends or invests its funds. It has therefore earned good yields on its money in the money markets in an effort to make its funds go further.

R2-BN TO BE SPENT

This earned the IDT an additional R350-million in interest in 1990/91. The IDT has also begun a concerted effort to raise more development money abroad.

IDT executives have warned that what seemed like "an enormous sum of money" a year ago, has shrunk in comparison to the massive demands that must be met.

The IDT's resources — and those of other development agencies — will have to grow quickly and strongly, they say, if there is to be a real hope of empowering South Africa's poor and making them more self-reliant.

Among the IDT's special programmes and projects have been:

☐ Creating a new low-risk stock for the Johannesburg Stock Exchange — called a Collateralised Housing Investment Paper — which will bring in money for shelter for the poor.

☐ The signing of a support agreement with Nelson Mandela and Mangosuthu Buthelezi which links peace with reconstruction and commits both their organisations to help the IDT, which is hoping to use development projects to support peace pacts.

IDT chairman Jan Steyn has identified some of the main features of the IDT's method of operating:

☐ Remaining a small unit, so that the greatest amount of money possible could reach its target — the 10 million poor people in South Africa;

☐ Aiming most of the money directly at the poor;

☐ Reaching as many poor people as possible;

☐ Being consistent and fair in allocating funds;

☐ Making sure the community is involved in every aspect of a project's development; and

☐ Building, wherever possible, a multiplier factor into investments, ie seeing that investments are made in such a way that other funds and efforts are attracted to a project, so that it grows even more.

Steyn said he had been disappointed by the fact that some businesses did not seem to want to think creatively and invest risk capital for the sake of national, and therefore business's, interests in the years to come. He welcomed, however, the contribution of visionary business leaders, especially those who supported the R500 million Private Sector Initiative under the leadership of Mr Mike Rosholt.

He criticised so-called "gatekeepers" who he described as often self-appointed and who demanded that they should have the power to approve new programmes in the community.

He distinguished between them and genuinely committed workers at grass roots who selflessly devoted themselves to the needs of the poor, and thanked them for supporting the work of the IDT and other development agencies.

Steyn said the pressure to move fast had been enormous, but that the IDT had felt it necessary to move carefully and sensitively in all its projects.

He warned that the IDT would not allow itself to be pressured for the benefit of interest groups, either business or political.

UCT plan to give all access to medicines

THE University of Cape Town's Department of Pharmacology Drug Action Programme aims to ensure all South Africans access to essential, safe, affordable and high-quality medicines.

The five-year, R600 000 programme was commissioned by the Department of National Health and Population Development.

The programme was aimed at the public sector which treated 80% of South Africa's population, head of pharmacology Professor Peter Folb said.

Because medicines were costly, a comprehensive plan was necessary to make sure essential medicines were available to combat prevalent diseases such as TB and diabetes, he said.

Co-operation with South Africa's traditional healers was also under way. (97) (85) 20/9/91

A need for self-reliance

20/9/91

(85)

THE IDT's approach to development strongly emphasises self-reliance, which is very important in view of the rapid and alarming breakdown of black community life, says IDT trustee Dr Mamphela Ramphele.

Ramphele, a sociologist and deputy vice chancellor of the University of Cape Town, says this breakdown can be seen in many aspects of black life.

Families break up. Many people are without jobs, and many others simply do not have the skills to get jobs even if jobs were available. Drugs and liquor are abused. Crime rates soar. Skilled successful people, who set a good example in their neighbourhoods, leave the townships.

Generally, despair grows until people believe they are victims who can do little or nothing to help themselves. Thus they lack the will to come to grips with these tough challenges, says Ramphele.

Ramphele makes two points. First, one finds similar situations among white working class people in Ireland and the United Kingdom. Pockets of this sort of breakdown can be seen in India. And in South Africa these conditions are found among many poor whites.

Secondly, it's not just an economic problem. Other factors include:

- ☐ the growing number of people living in the cities;
- ☐ how badly off people think they are;
- ☐ and if they think they have been exploited, their belief that the government, or the rich, "owe" them a better life.

Ramphele calls this "the culture of entitlement", and notes that it has thrived on the huge gap between rich and poor in South Africa.

All of this was made worse by the strategy of "making South Africa ungovernable", which relied on mass mobilisation, school and consumer boycotts, people's courts and other alternative structures which depended on force and intimidation to get people in line.

For "victims", the "victim" image has been an important

Primary care at the heart of health needs

(85) AMG 20/9/91

HEALTH

FIFTY-TWO projects in the areas of health and rural and comunity development claimed R135,5 million in IDT funds up to July 31, 1991.

Another nearly R30-million was set aside for the welfare sector to encourage community services.

Spending in this IDT portfolio will rise to R514-million over the next two years. All told, the IDT's trustees will be askd to approve about R400 million for health, rural and community development, and about R120 million for welfare.

Making a major impact on people's basic health — especially in rural areas where the poorest live — means dealing with the development issues that affect it, says IDT trustee Prof Mamphela Ramphele, who designed the strategy with Professor Len Karlsson, who is now director of this portfolio.

The IDT has three major focuses. The first is on primary health care. This is aimed at bringing basic affordable health services and facilities to all the people, especially in rural areas where effective care has all but collapsed. Funding will go into:

- ☐ properly coordinated training programmes for voluntary and community workers as well as doctors and nurses;
- ☐ properly staffed and equipped healh centres, clinics and visiting points, in which the community is involved from the outset;
- ☐ water and sanitation. Without exception, communities have made drinkable water their highest priority;
- ☐ electrification. Talks are being held with Eskom to push this part of the programme ahead;
- ☐ a major AIDS education and care programme that will run alongside the one started by the Department of National Health; and
- ☐ a big drive to reduce TB in the Western Cape by 50% over the next three to four years.

The IDT's second major focus in this portfolio is on welfare. In a definite move away from old policies, the IDT will fund services that will allow voluntary workers, guided by professionals, to give care to the aged, to cancer patients, and to other people who get welfare, in their homes.

The third focus is on rural and community development. Here the main thrust will be to strengthen organisations throughout the country that are running good programmes, but which need a lot more money.

These involve mainly agricultural and forestry projects, for example woodlots that will help slow down the rate at which forests in rural areas are being destroyed.

The IDT would like to see a single national health policy, and is helping bring together the 14 different departments of health and other major players.

Already, different organisations have started to work together in combined programmes.

The approach, says Dr Ramphele, "should enable us to move from a fragmented, inequitable health service, to one which takes care of the needs of everyone".

Prof Karlsson adds: "We're looking for partners from any side, with successful programmes going in these fields, that we can support."

Japan gives R4,2m to SA trust

JOHANNESBURG. — The consul-general of Japan, Mr Masatoshi Ohta, yesterday formally declared the Japanese government's intention of contributing R4,2 million to the Kagiso Trust for aiding disadvantaged South Africans in 1991. (59) (85) CT 21/9/91

During a brief "exchange of notes" at a hotel here, Mr Ohta told Kagiso chairman Dr Abie Nkomo that the contribution was in support of projects mainly in educational and medical areas. — Sapa

Visitors to check on apartheid

TWO physicians have arrived in South Africa to examine the extent to which apartheid still exists in healthcare in South Africa.

The two, Dr Tony Waterston of Britain and Dr Gilles de Wildt of Holland, were sent here by the British-based Physicians for Human Rights and the Dutch Foundation for Health and Human Rights.

Their visit follows an announcement in May 1990 by Health Minister Dr Rina Venter that people of all races would have access to health services.

Sowetan 24/9/91

Discussions

The two doctors will go to various hospitals, clinics and private doctors around the country as well as have discussions with the National Medical and Dental Association, Government officials and other medical associations, said a Namda statement.

They will then compile a report and hand these to their respective organisations and government bodies in their countries.

The two doctors are scheduled to leave South Africa at the beginning of October. — *Sapa.*

PRIMARY CARE AT THE HEART OF HEALTH NEEDS

H·E·A·L·T·H

South 26/9 – 2/10/91 (85)

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Health care '85 dependent on economy'

Star 27/9/91

Political Correspondent

President de Klerk has warned that South Africa will not be able to afford any dramatic adjustments in health spending for years to come and will have to cope with available resources.

Officially opening the new R166 million wing of the Groote Schuur Hospital, Mr de Klerk said health was a priority and would not be neglected, but the fact was that there were several areas of critical need, such as housing and education.

"Until we have strong growth in the economy based on sound economic policy and principles, we will simply have to cut our cloak according to the cloth," he told the gathering.

Mr de Klerk evaded a phalanx of protesters at the official opening of the new hospital wing, but was unconcerned about what he regarded as a reflection of the "growing pains" of the new South Africa.

As protesters voiced their opposition to the newly built wing at the main entrance, Mr de Klerk slipped in through a side entrance.

Cape medicine plan go-ahead

86 CT 28/9/91

BLOEMFONTEIN. — The Administrator of the Cape has successfully appealed against a judgment that found that the provincial administration's scheme to repackage and distribute medicines, without the approval of the Medicine Control Board, was illegal.

The repackaged medicines were for distribution to district surgeon patients by district surgeons and district pharmacists.

In the Cape Supreme Court on October 29, 1990, Mr Acting Justice W A van Deventer granted an application by Raats Rontgen and Vermeulen (Pty) Ltd, which conducts pharmacy businesses in the Boland.

Their objection cited the Medicines and Related Substances Control Act, which controls the quality, manufacture and dissemination of medicines.

Yesterday Mr Acting Justice Kriegler, with the concurrence of Mr Justice Botha, Mr Justice Hefer, Mr Justice Nestadt and Miss Acting Justice Van den Heever, found that the act must be held not to apply to the CPA.

CPA property

The crux of the matter, the judge said, was that it was never mentioned that it was the "sale" by the provincial hospital to the district pharmacist that was regarded as an objectionable feature of the scheme.

The draft contract for the appointment of district pharmacists made it plain that prepacked stocks of medicines supplied in terms of the contract remain the property of the administration.

The judge said it was clear that the pharmacist's position was tantamount to that of a skilled storeman in control of the administration's stock. He was to part with it only as and when instructed in writing by the local district surgeon by means of a particular form of prescription.

Therefore, it was clear the medicines remained the property of the CPA — and that they would comply with the accepted standards and specifications.

The judge said no other ground to invalidate the administration's scheme had been suggested, nor could any be perceived. — Sapa

Health professionals to support VAT protests

Soweto 30/9/91

THE SA Dispensing Practitioners have decided not to charge Vat for medical services and dispensed medicines, and to close all medical practices for one to two days to register protest.

The chairman of the SADP, Dr P J Maelane, said his organisation had appealed at a meeting in Soweto to patients to use public services during the closure, and apologised for the inconvenience. He did not say when the planned closure would take place.

He said the SADP also resolved to ask all health professionals to support the campaign "in the public interest", as well as to appeal to medical aid societies association, Rams, and other independent medical schemes not to increase subscriptions because of Vat.

Campaign

Maelane said practices would display signs informing patients that they would not be collecting Vat.

"We also appeal to the SA Medical and Dental Council to support our campaign on moral and ethical grounds," he said. - *Sapa*

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business practitioner, and disseminate information pertinent to this sector among members.

Big business could be "part of small business" by planned purchases from this sector, joint venture funding, sub-contracting, in-house small business units, continued financial support and training.

Marais could not be reached for comment yesterday.

New standards for agricultural products

B Day 2/10/91

GERALD REILLY

PRETORIA — Agriculture Minister Kraai van Niekerk yesterday announced the implementation of new legislation to enforce quality standards on agricultural products.

Van Niekerk said the Agricultural Products Standards Act consolidated the Dairy Industry and the Agricultural Export Acts and incorporated some sections of the Marketing Act.

He said the provisions would control sales on local markets and the export of specific farm products, and laid down minimum requirement for packaging.

Quality control was an important component in local and international marketing of farm produce, he said, adding that it was government's approach to let industries apply quality control on its behalf.

SA's need for aid 'massive'

GENEVA — A future democratic SA would need "a fairly massive programme of assistance" to help tackle the effects of years of discrimination against blacks, a UN official said yesterday.

Basem Khader of the United Nations Development Programme (UNDP) said the international community must be ready to mount housing, education and employment programmes.

But he told a news conference government would be expected to "assume the bulk of the responsibility".

Khader urged the UN General Assembly, meeting in New York, to relax restrictions on UN activity in SA to allow the organisation to set up a base.

The UN High Commissioner for Refugees recently set up offices in SA under a special agreement with government, but no other UN agencies are present because of a long-standing policy against apartheid.

For the past 20 years, UNDP has confined its activities to helping national liberation movements such as the ANC.

Khader spoke to journalists after a one-day meeting to discuss technical assistance to SA. Representatives of the World Bank, the Economic Commission for Africa, the African Development Bank, the Commonwealth Fund for Technical Co-operation, the EC and the UN Centre Against Apartheid also attended.

No SA delegates were present.

Khader said government officials had been briefed on the talks but had not yet indicated whether they supported the planned programmes.

Khader said the UN would only implement aid programmes after SA adopted a new constitution and had a racially representative government.

He said the cost of such assistance was not yet known, but it would likely be much higher than the estimated $250m to $300m in aid currently received from the US and EC.

"We need to be prepared for a fairly massive programme of assistance to SA to redress the imbalances so far," he said.

Further meetings would be held every six months and would focus on likely programmes in the housing, education, employment, health and rural development sectors. — Sapa-AP.

Visits herald new era for medical research

B Day 2/10/91

CAPE TOWN — An unprecedented number of official visits to SA by world-renowned medical research experts since the beginning of last month indicates a promising era for medical research in SA.

This is the view of Medical Research Council deputy president Prof Walter Prozesky.

He said visitors to SA over the past few weeks included Poland's Medical Research Centre director; a seven-member AIDS delegation from Atlanta's Disease Control Centre; and an official group from the French National Institute for Health and Medical Research.

"This is exceptionally positive for medical research in this country. "For the first time in more than a decade, we are again experiencing a wealth of scientific exchange which will benefit the health of all South Africans.

"If these visits are the sign of times to come, through active scientific exchange our medical experts will once again be well on the way to firmly establishing SA as a country with expertise which is of immense value to Africa and the international scientific community as a whole," Prozesky said. — Sapa.

UK orders sleeping pill withdrawn

(85 CT 3 21/10/91)

LONDON. — Britain yesterday ordered Halcion, the world's most widely prescribed sleeping pill, withdrawn from pharmacy shelves because of safety concerns.

And medical authoritites in South Africa are investigating the drug.

The chairman of the SA Medicines Control Council, Professor Peter Folb, said the issue was being treated "as a matter of urgency and priority".

Local pharmacist Mr Benard Crane confirmed that Halcion was widely used in South Africa.

Britain's Department of Health said Halcion and other drugs containing triazolam were associated with a much higher frequency of psychiatric side-effects, particularly loss of memory and depression, than other sleeping pills.

"It is now considered the risks of treatment with triazolam outweigh the benefits," it said.

US manufacturer Upjohn Co has asked for a hearing from the Committee on the Safety of Medicines (CSM), the British regulatory body.

Earlier, Upjohn refused voluntarily ro remove the product prior to suspension. "There is absolutely no scientific or medical evidence that warrants withdrawal of Halcion tablets in the UK or any other country," Upjohn chairman Mr Theodore Cooper said in New York.

Halcion was launched 14 years ago, is registered in more than 90 countries and has been the target of at least one patient lawsuit.

The patient, Ilo Grundberg, sued Upjohn in Utah in the United States after she was charged with second-degree murder for killing her 83-year-old mother. She said she had no memory of the murder and pleaded that she was involuntarily intoxicated.

The murder charge was dismissed and Upjohn reached an out-of-court settlement with her in August. — Sapa-Reuter, Staff Reporter

Duduza makes history

WOMAN

Sowetan 8/10/91 (85)

A CLINIC constructed out of tin containers, the first of its kind in the Southern Transvaal has been opened in Duduza, Nigel.

By BULI SIWANI

A group of local businessmen who call themselves Corporate Outreach Trust, donated the containers towards the clinic's construction.

Dr Rina Venter, Minister of National Health Services and Welfare officially opened the clinic which is situated in the middle of the township's informal housing sector.

She spoke of the poor socio-economic conditions and how they lead to consequent health problems in poverty-stricken communities.

"The rapidly increasing urbanisation process has had vast implications on the health situation of communities living in informal housing around our cities," Venter said.

"The prevailing poor living conditions and unemployment in the areas have also led to the lowering of the standard of living and consequent health problems in these disadvantaged communities."

She said that provision of primary health services helped to prevent unneccessary deaths and alleviated much human suffering.

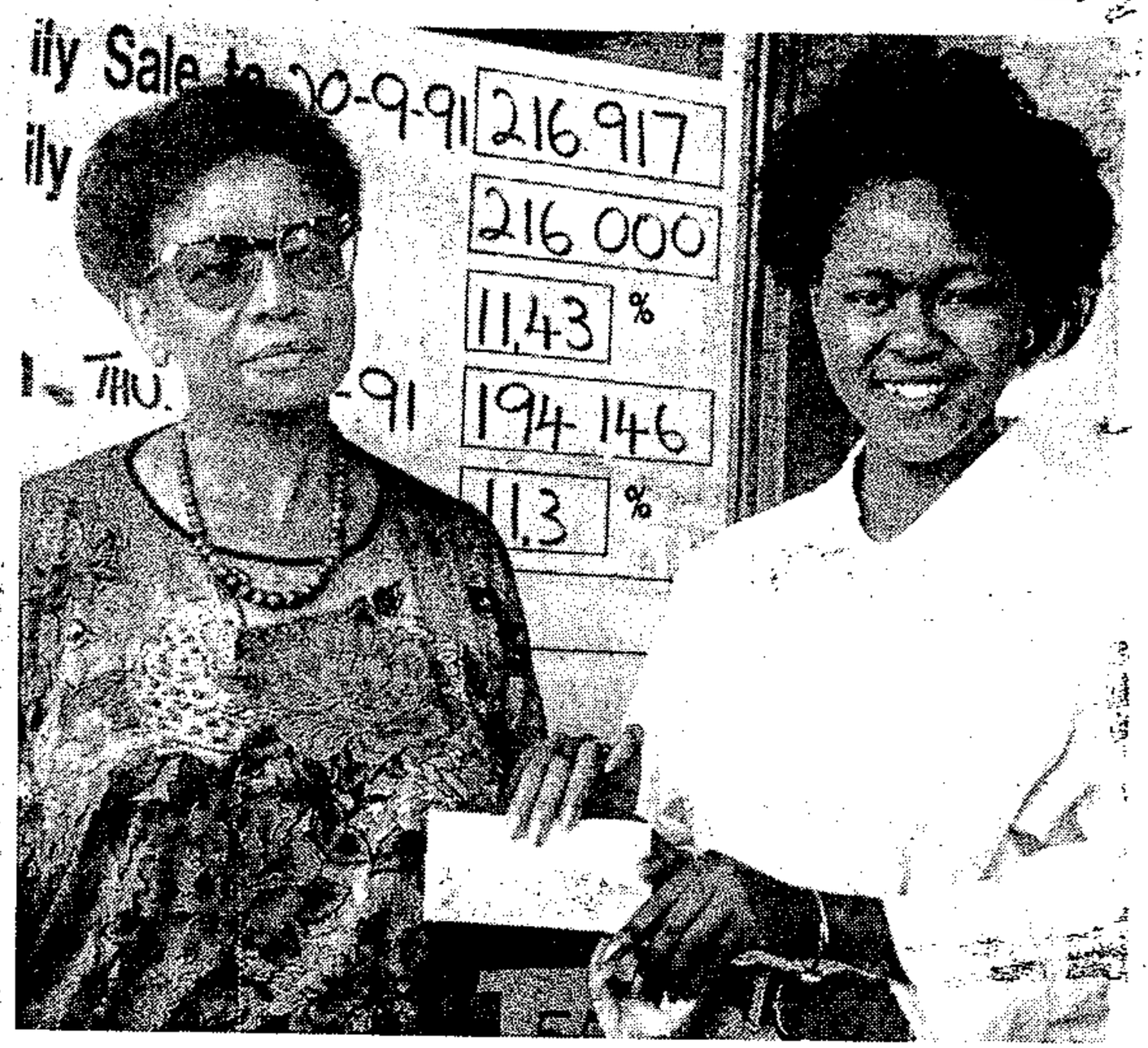
Primary health care services entail health education on many aspects of health, as well as a healthy life style, advice on nutrition, mother and child care including family planning, immunisation and the treatment of diseases that are common in the community.

Venter said the Government, health authorities and the private sector could only be defined as facilitators and that without community participation it was unlikely that primary health services would succeed.

"Although the Government is responsible for ensuring that health services are available, it does not mean that the Government has to render the health sevices on its own.

"We have evidence of community participation through the involvement of the Duduza Town Committee," she said in praise of the association.

Dr W Clewlow, of Barlow Rand Limited and a member of Corporate Outreach Trust, said it was sheer ingenuity on the part of Duduza businessmen that they had the vision to convert the containers into something.



Businesswoman Angie Makwetla presents a cheque for R200 to Buli Siwani of *Sowetan Woman*. The cheque will go to the *Sowetan* /DMZ Relief Project. Makwetla has challenged all businesswoman to equal or exceed her donation to the project which will benefit victims of the recent spate of violence in the Reef.

Health care for all becomes everyone's concern

Journalists were taken on a joyride of a different kind recently. NOEL BRUYNS reports on Project Healthy Nation.

IT COULD HAVE been a foolproof CCB abduction operation: 100 journalists who met after sundown at the Sandton Sun Hotel outside Johannesburg last week were whisked away in coaches with the windows totally blacked out.

"We can't tell you where you're being taken to," was all the anxious reporters were told as the coach cruised through the night.

Half an hour later, they disembarked and were herded straight into a nondescript building without being able to look around to establish where they were.

Inside, they entered a cavernous room with black drapes covering the walls entirely; there was not even a window to look through.

But the suspense was lightened when they were presented with champagne and orange juice, smoked salmon, oysters and other snacks, and a string quartet stroking out soothing classical music.

"Ladies and gentlemen, this is not your final destination," said a dapper young man in a tuxedo. "Please remain confused for a while longer, until you are taken to the final venue."

The final venue was reached by leaving the room through a tunnelled passage that, puzzlingly, led to what seemed to be a rural township, with dozens of African people milling about, apparently oblivious to the journalists.

There was a spaza shop, ululating women and dancing children on the stoep of a township shebeen, a man cutting another's hair on the side of a gravel road, and a rural health clinic.

Eventually, everything was explained. We were at a film studio on the Midrand set up as a rural village, with TV2/3 actors playing the "locals".

It was the scene for the launch of "Project Healthy Nation" initiated by the Department of National Health and Population Development, which had invited journalists to experience an example of where primary health care is most needed in South Africa.

The suspense in which the journalists had been kept the whole evening was an effective promotional ploy — all the more so considering that a government department was involved.

The Department's obvious efforts in organising "Project Healthy Nation" may be indicative of the seriousness with which it views the challenge of primary health care.

"Almost all countries in the world are working towards the goal of 'health for all by the year 2000'. The only way in which this goal can be reached is through primary health care," said the Department's director-general, Dr Coen Slabber.

"Project Healthy Nation" aims at increasingly involving the general public, welfare and community organisations, churches, the private sector and the media, in primary health care in order to increase everyone's basic knowledge of health care and skills.

"The Department still accepts full responsibility for the health of the South African population, but on a basic level it cannot cope alone," Slabber said.

Dr Paul Vorster, director of a communications agency commissioned by the Department of Health to promote the launch, explained the Department's approach with this example: If a farmer has a worker who falls ill, he should not have to take him to the nearest town for treatment, but should be able to have him treated with the primary health care facilities he has created on his farm for the workers.

Asked whether community organisations had been approached to endorse and support the project, Vorster said: "For the project to succeed and to ensure those who need primary health care in fact receive it, we need the support of all communities."

Several community leaders, including Dr Nthato Motlana of Soweto, have signed a "Health Pledge" to support the spread of primary health care.

The "Project Healthy Nation" launch was also marked by a new television commercial, drawing a parallel between the suffering and disease many South Africans face daily and the emotional "trauma" of a roller-coaster ride.

The commercial gives an address to which community leaders and leaders in organised commerce, industry and agriculture may write to encourage the spread of health-care knowledge through existing channels. □

DR NTHATO MOTLANA: Signing the "Health Pledge".

NP CAPE CONGRESS

Du Plessis defends VAT on medicine

(85)

B|Dav 9|10|91

STRAND — VAT on medical services was not a question of morality but one of practicality, Minister of Finance Barend du Plessis told the Cape National Party congress yesterday.

"We do not choose to be sick, but neither do we choose to be hungry. If we are really sick and cannot afford the costs, we can go to a state hospital, but where do we go to find food?

"I have never seen an official statement from a medical association when medical costs have risen by as much as 18%.

"That money goes into the doctor's pocket, but VAT goes to the state, and 40% of it is used for social upliftment.

"I've also never heard doctors, who are shareholders in private medical institutions, objecting when tariffs at those institutions have increased."

He said 80% of people receiving medical attention did so at the cost of the state.

There were two sources of tax — from the production side, and on consumption. GST taxed goods and only a few services, and this created major discrepancies because, as society became more sophisticated, its consumption extended beyond goods and into services.

The poor person paid GST on goods like candles and wood while the wealthier person paid no tax on electricity.

"Tax on services extends the tax base and makes it possible for the rate to come down," said Du Plessis.

Regarding the protest culture in townships of not paying for rentals or services, Du Plessis said it had to come to an end as it would mean the death-knell of investment in the townships.

He said the person who borrowed money to build a house and did not repay the loan, "shoots his neighbour in the foot, if not in the head".

"This business of non-paying in the townships, this protest culture, is the death-knell of investment in the townships. This whole culture must be broken," Du Plessis said. — Sapa.

Cuban health system for SA?

Cipres 13/10/91

By THEMBA KHUMALO

SOUTH Africa should follow the Cuban health system as one of the best alternatives to our fast-deteriorating health services, suggests a document handed to Cosatu.

The document on the inequalities in the health services provided for various communities was first circulated two months ago at the Cosatu conference by health service researcher Gopolang Sekobe. However, there was no time to discuss the proposal.

Sekobe is highly critical of the privatisation of health institutions and says this system consumes 50 percent of total health financing while only caring for 20 percent of the population.

In Cuba, ordinary people are involved at every level in the health service, through committees for the defence of the revolution, women's movements and trade unions.

Community organisations work with professionals to meet set health objectives. The system is financed by the State, but administered locally.

This system leaves the practitioners free to treat patients as they see fit, without the drive of a "fee for a service".

This often results in lower rates of surgery with the same outcome for the same conditions compared to other countries.

In the alternative scheme proposed for South Africa, employers would contribute a percentage of annual turnover to a tax for national health.

Industries producing health risk items, such as cigarettes and alcohol must pay a double tax.

These levies would be used to fund research on safer material, work activities and machinery.

Patients to fork out 25% more

(86) ET 15/10/91

Staff Reporter

DOCTORS were awarded a 16% pay rise to off-set the effects of inflation — but subscriptions could rise by 25% or more and the medical industry has expressed fears about its survival in the face of rising private health costs.

The Representative Association of Medical Schemes (Rams) yesterday announced the increase in its scale of benefits to take effect from January 1, 1992.

Rams said dentists, private hospitals, day clinics and other providers of medical services would receive an average increase in payments of 16%.

Increases would depend on the individual schemes. Their expenditure was affected by two factors: The cost of providing a service and the frequency with which it was used.

The latest increase comes on the back of the 8% rise to compensate for the effects of VAT.

Rams executive director Mr Rob Speedie said private health care costs were expected to rocket by nearly R1 billion next year to at least R7,6bn, "if over-use of health care goods and services continues at the current rate".

In 1987 South Africa's private health care bill was below R4bn.

Mr Speedie said increased costs were not due to more people using medical schemes but to the fact that users of medical aid had "gone on a consumption spree".

"If users and providers of services were more responsible, it would cut tens if not hundreds of millions of rands from the budget," he said.

To counter the spiral "more and more" medical aids were looking to the introduction of no-claim bonuses and penalising excessive users by raising individual subscription rates.

Medical Association of South Africa secretary-general Dr Hendrik Hanekom said the "indiscriminate use of services" could jeopardise the future of private health care.

The Medical Association of SA (Masa) was alarmed at the fast-rising costs of health care and had called for a concerted effort to slow the spiral, he said.

Dr Hanekom said Masa would continue to fight for the exemption of all medical services from VAT.

SA medicine 'harmed by isolation'

B/Day 15/10/91

DAVE LOURENS

SA's academic isolation of the past 10 years had taken its toll on medical standards, according to international neurologist Prof Ottar Sjaastad of Norway.

Speaking before his return to Norway last week after a 10-week lecture and research tour, he added that it appeared there had not been sufficient financial resources available to support advanced research.

This was a tragedy, as there were top quality people in the neurology field and SA was clinically up to international standards.

He said standards in neurology would drop if sufficient money was not found for academic research.

"Funding is poor, and salaries are poor. Young doctors prefer private practice to doing research."

Sjaastad, one of the world's foremost experts in migraine research, worked with Medunsa neurology department's Prof Jacques Joubert and gave lectures on successfully diagnosing migraines as opposed to other headaches.

He also assisted Joubert in interviewing more than 800 migraine sufferers in Zululand.

He said up to 6% of people suffered migraines, which was often a hereditary disease.

Meanwhile, Glaxo pharmaceuticals corporate affairs manager Martin Jennings announced this week that an innovative drug was in the pipeline for migraine sufferers.

It had already been introduced in Britain, New Zealand and Holland, and was planned for introduction in SA early next year, subject to registration.

Jennings said Sjaastad's lectures had been invaluable in raising consciousness of migraines among general practitioners and opinion leaders.

Jennings said much pain was needlessly endured because sufferers were reluctant to consult doctors with "mere headaches".

Health services 'being altered'

SOUTH AFRICA'S health services are being democratised and decentralised, says Minister of National Health Dr Rina Venter.

"Community participation will encourage self-help, self-reliance and self-respect," she told a National Cancer Association volunteers' symposium in Cape Town yesterday.

The restructuring had been necessitated by increasing criticism of a health-care system which did not fulfil the expectations of the population, she said.

People 'terrified' of illness as medical costs rocket

Staff Reporter

People "are terrified" of getting ill because of soaring medical bills, Housewives' League president Lynne Morris said today.

She was reacting to the Representative Association of Medical Schemes (RAMS) announcement yesterday of an average 16 percent increase in its 1992 scales of benefits for doctors, dentists, private hospitals and day clinics.

Mrs Morris said people "cannot afford to get ill any more".

RAMS has forecast that the cost of private health care will rise by more than R1 billion to at least R7,6 billion in 1992 — chiefly because South Africans over-utilise services.

Total

And if this over-utilisation continues, the total bill could pass R8 billion, says executive director Rob Speedie.

As a result, medical aid subscriptions may go up by, on average, as much as 25 percent in the first quarter.

The scale-of-benefit increases come after an 8 percent rise on September 30 to compensate for VAT.

Some other practitioners will receive 15 percent.

At the top of the scale is a 33 percent rise for intensive care units.

"For the man in the street, private health care is becoming increasingly unaffordable with the passing of each year," Mr Speedie said.

To illustrate the point, he said medical schemes would probably pay out an average of R275 per member a month for services next year, compared with R98 in 1987.

Towards a healthy S Africa

A new health policy is on the cards reports HEATHER ROBERTSON.

South (Southside) 9|10-16|10|91 (85)

South Africa's current health care system is infected with two of the most chronic social diseases — apartheid and privatisation. But many in the medical professions argue both are curable and preventable in the long term by a new health policy geared towards primary health care in an equitable national health program.

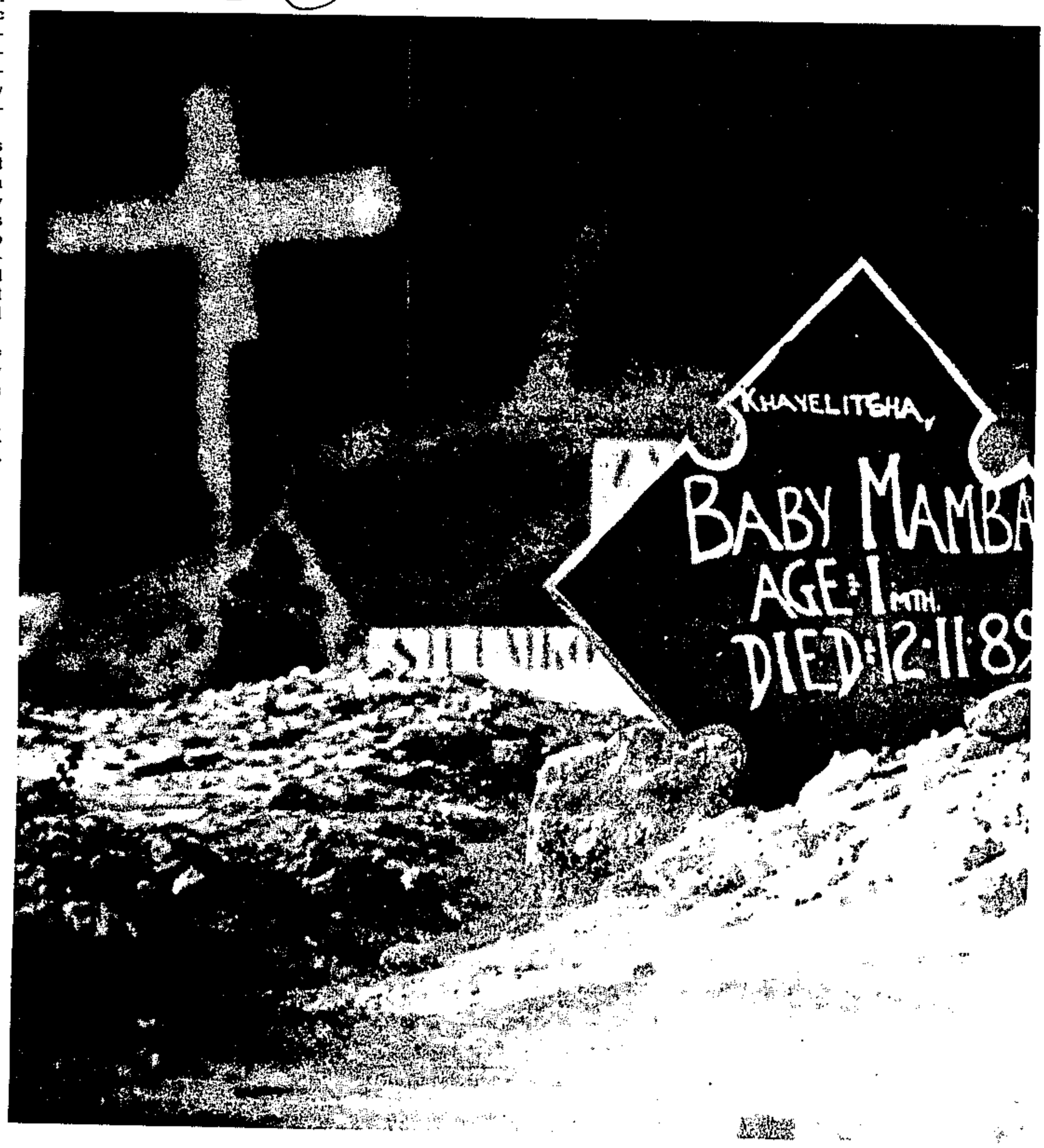
Progressive doctors and health care workers in organisations like the National Medical and Dental Association (Namda), South African Health Workers Congress (Sahwco), Primary People's Health Care (PPHC) and the ANC's Health Department are rallying together to remedy the situation with health policy alternatives. The establishment next year of a unified non-governmental health body, the National Progressive Primary Health Care Network, will be well placed to shape a new health system.

Various commissions on health policy have been set up by the ANC to investigate policy alternatives headed by some of the country's top doctors and health care professionals.

Krish Valabhjee, President of Sahwco, cautions that, despite these plans, the prospects of attaining the World Health Organisation goal of "health for all" by 2000 are not realistic.

"We should be alert to the fact that such unrealistic slogans raise expectations among the general population which may yet be the undoing of a democratic government."

In a paper presented in Progress journal he argues that the major challenge is economic, specifically the question of how to establish national priorities which balance the limited available resources with the enormous developmental backlog.



'Most people in squatter areas and black townships suffer diseases of deprivation while many wealthy white and black people who have access to private care suffer from diseases of excess like heart diseases and lung cancer.'

There is broad agreement in the progressive health sector that the ultimate objective is a National Health Service that is:

- centrally planned
- decentralised to allow for community control
- built around comprehensive primary health care
- holistic with a developmental approach as opposed to the state's current curative service-oriented approach.

This would mean a single national health department should be established as opposed to the redundant 14 departments of health.

Dr Kamy Chetty, who heads the ANC's commission into a national health policy, argues health care should be seen in relation to housing, employment and education.

She cites the high infant mortality amongst black children as an indication of the extent of the current problem.

"The white infant mortality rate in 1987, according to the Cape Town city council, was five deaths for every 1 000 live births. The Coloured rate was 16 deaths for every 1 000 live births and the African rate was 30 deaths for 1 000 live births. "

"The infant mortality reflects socio-economic conditions where preventable diseases, like measles and gastro-enteritis are still the primary cause of deaths," says Dr Chetty.

"Most people in squatter areas and black townships suffer diseases of deprivation while many wealthy white and black people who have access to private care suffer from diseases of excess like heart diseases and lung cancer."

Whereas previously the health care system was fragmented between race groups, at present there is still fragmentation between 14 health departments, curative service provincial hospitals and preventative service clinics.

"We still have an apartheid health system because white people generally have access to hospitals and private doctors while black people still don't have access," says Dr Chetty.

While South Africa has sufficient hospital beds, there is a drastic need for community clinics, she argues. According to the World Health Organisation there should be one clinic for every 10 000 patients.

In the Free State there are 27 000 blacks and 6 000 whites for every clinic. In the Cape there are 11 000 blacks and 6 000 whites for every clinic.

A doctor on the South African Medical and Dental Council concurs with the ANC. "We do not have a shortage of doctors. We have a maldistribution of doctors and all health professionals who invariably work in the metropolitan areas to the exclusion of the rural areas."

"The emphasis is all wrong. It should be on primary health care. However, despite the fact that we are a predominantly third world country, we have seen an ever-increasing trend towards high-tech medicine.

He cites as an example the fact that there are more magnetic resonance image intensifier scanners (MRI scanners), which cost close to R2-million, in Johannesburg than in the whole of Australia. There are also more in South Africa (14) than in the whole of the UK."

"What is more, all except one of these are in private practice and in a single private practice in Johannesburg there are three."

An MRI is a highly sophisticated machine used to pick up cancerous malignancies and lesions at an early stage. A scan costs R2 000.

Because the medical industry is geared towards expensive hi-tech operations and surgery, many small-town general practitioners attempt to make money by dispensing unnecessary medicine.

"Many dispensing doctors abuse their right to dispense simply because the patient does not have to pay himself. For example, one black doctor in the Transvaal dispensed some 11 items, including three duplicates of potentially harmful drugs for no other reason than that the patient was 'covered by Medical Aid'.

"Medical aid societies have intruded into the hitherto sacrosanct doctor patient relationship. The really scary thing is that our very medical priorities for our future medical educational needs are also being decided by these intruders.

"In a system like ours it has always been understood that the brightest students not only remain within academic medicine but in surgery."

As the medical aid tariff was originally decided between Rams (the Representative Association of Medical Aid Schemes) and Masa (Medical Association of South Africa), and as these top doctor officials were then and still are from the surgical disicplines, the tariff is riddled with anomalies. Surgical procedures are remunerated disproportionately to the time and skill involved. For example, if a doctor spends 45 minutes counselling a patient, he is paid R33,10 while if he lances a boil, which takes about six seconds, he is paid R41,40.

According to Dr Chetty the new Medical Schemes Act gives more power to the medical aid societies. The ANC is looking into national health and insurance systems with more checks and balances on how the health budget is spent.

But there is broad consensus, in keeping with the ANC's policy of a mixed economy, that there is scope for private medicine. An ANC government would, however, change the budgetary emphasis from spending on private medicine to focus on the development of a public health system which provides adequate health care facilities in the communities.

At present the government spends 46 percent of the total health budget on the private sector, which caters for 20 percent of the entire population. Fifty percent of South African physicians are in private practice.

Vallabjhee views this as another major obstacle to attaining an equitable health system.

While changing the health system is a major task, the reality is that a new government cannot start with a clean slate, but rather build on what exists.

SALT RIVER • OBSERVATORY • MOWBRAY • ROSEBANK • RONDEBOSCH • NEWLANDS

Garbage removal cut a 'health risk'

(85) CT 16/10/91

THE Cape Town City Council's decision to reduce household refuse removals in the southern suburbs from twice to once a week was a potential health hazard, according to the city's Medical Officer of Health.

Dr Michael Popkiss said the city health department was unhappy about the decision and had opposed it in the council on grounds of public health.

He said: "The fact is that black bags tear. Dogs rip them and flies get in. Fewer collections also mean there will be two to three times the amount of rubbish scattered about, which in turn creates an easy meal for rats.

"We believe the only way to control fly-breeding and an increase in rats is by the rapid removal of garbage."

The council hopes to save about R3,2 m a year by reducing the garbage removals.

Dr Popkiss said a previous attempt by the council to reduce the frequency of refuse collection in Bergvliet had been bitterly opposed by local health authorities as well as residents in the area.

He said: "Our role will be to monitor the situation.

"We also urge members of the public to report any perceived health problems to the nearest district office of the Medical Officer of Health."

However, when approached for comment, many home-owners in the southern suburbs said they did not think they would be adversly affected by once-a-week collections — mainly because they recycled a large portion of their garbage.

Biodegradable

Some people also felt strongly that the council should have introduced an environmental awareness campaign to encourage better home-management and recycling of waste before reducing the frequency of removals.

Mrs Wendy van Wyk, of Mowbray, said: "If it was more economically viable for families to recycle tins, plastic, paper and glass the amount of garbage could be greatly reduced."

She said that excess biodegradable waste could also be added to compost heaps.

A Press statement issued by the council said a once-a-week service had already been introduced in most municipalities throughout the country.

The system was being introduced to Cape Town on a phased basis, first in an area stretching from Bergvliet to Mowbray.

Garden refuse

Notices have already been issued to householders in some affected areas and the council hopes to complete the first phase by the end of November.

Black bags will continue to be used, with green bags for garden refuse.

The maximum number of bags per household will be five and the council will remove up to a cubic metre of excess garden refuse at no cost if this is requested of the local district manager.

Biko doctor: SAMDC move slammed

Star 20/10/91 (85)

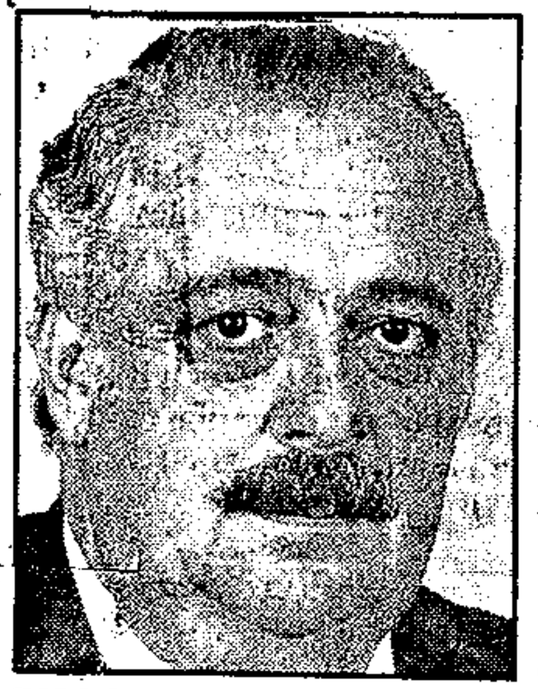
Chris Barron

ONE of the six doctors who took Supreme Court action to force the SA Medical and Dental Council (SAMDC) into holding an inquiry into the conduct of Dr Benjamin Tucker has called its decision to reinstate him six years after being struck off the roll, "a foolish strategic more".

Professor Frances Ames, at the time head of neurology at the University of Cape Town and Groote Schuur Hospital, this week criticised the SAMDC for showing "a singular lack of sensitivity" and feared its move might suggest to doctors both here and abroad that it was "still not taking the matter seriously".

"I don't feel personally vindictive towards Dr Tucker. My argument is with the SAMDC for their whole attitude to this thing."

Coming after its "unbelievably grudging response" when the Supreme Court forced the SAMDC to hold an inquiry into the conduct of Drs Tucker and Ivor Lang eight years after Steve Biko's death in detention, Professor Ames felt the council's decision was "a foolish strategical move at a time when everyone is trying to promote the image of a new South Africa."



DISAGREES WITH THE ACTION . . . George Bizos.

Advocate George Bizos, a member of the team that represented the Biko family at the inquest into his death, said that although "one must try to forgive and forget" he found it "somewhat difficult to accept that Dr Tucker has paid fully for his dereliction of duty after such a comparatively short period.

IT WON'T BRING STEVE BACK . . . Ntsiki Biko.

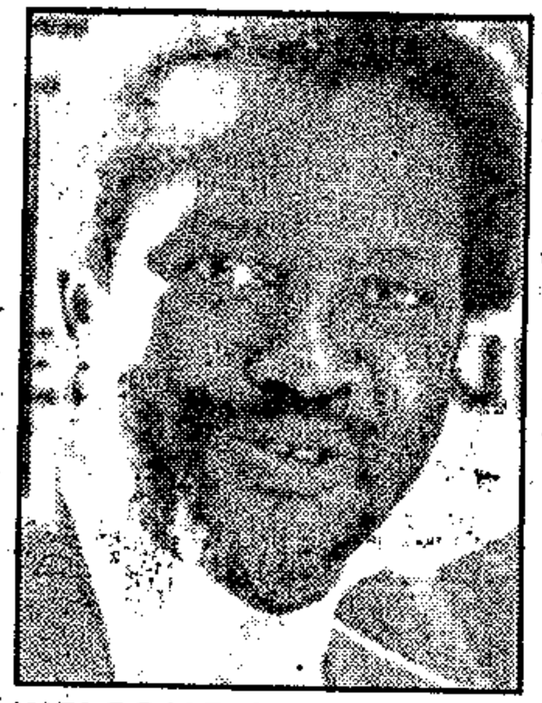
"The primary responsibility for Biko's health was Dr Tucker's," he said. "I know of no greater dereliction of duty than he was guilty of."

On the other hand, another of the doctors who took the SAMDC to the Supreme Court for its failure to act on the doctors involved in the Biko case, Professor Trevor Jenkins, said he did not "feel too aggrieved" about the decision to reinstate Dr Tucker.

"Doctors can make mistakes and learn from them," said Professor Jenkins, head of human genetics at the School of Pathology at the SA Institute for Medical Research and Wits University.

"In my opinion the real villain was the SAMDC. We wanted to bring it to order for not doing its job, not holding a full inquiry."

Professor Jenkins said he found the SAMDC's stated reason for re-instating Dr Tucker — that he had "fulfilled the necessary requirements" — "intriguing".



WELCOME BACK . . . Dr Nchaupe Mokoape.

"I remember at the time Dr Tucker felt he had been hard done by. He believed he had done nothing wrong and would do the same under similar circumstances."

Mr Biko's widow, Ntsiki Biko, said nothing Dr Tucker did would sufficiently atone for not looking after her husband properly when he was in detention.

"I have no feelings about his reinstatement one way or the other," she said. "Whether he is re-instated now or later is not going to bring Biko back."

A leading member of the BC movement this week congratulated Dr Tucker on his re-admission, reports Yogin Devan.

Durban-based medical doctor and deputy president of the Azanian People's Organisation, Dr Nchaupe Mokoape, said Dr Tucker had paid "for his dereliction and I would not be more vindictive than that".

"One has to understand that a person like Dr Tucker was operating in a political milieu in which black life was cheap. He has paid his dues and let us hope he will mind his life and leave the past behind."

DP, ANC agree on health-services funding

(85) CT 21/10/41

JOHANNESBURG. — The ANC and the DP found common ground in talks on funding for health services on Saturday, DP MP Mr Mike Ellis said.

"Although sometimes the way we say things is different, what we mean is . . . very much the same."

His party believed there was an important role for the private sector in the development of health-service care, Mr Ellis said.

Head of the ANC health secretariat Dr Tim Wilson said at the talks that the ANC believed there should be free medical services for all South Africans.

To achieve this, the government should limit the amount of funds going to the private sector and increase the amount for the public sector, he said. — Sapa

MASA won't back doctors' VAT protest

Star 21/10/19

By Carina le Grange

The Medical Association of South Africa (MASA) has said it could not support protest action by doctors against VAT on medical services if the action involved the closing of surgeries.

The Society of Dispensing Family Practitioners (SDFP) earlier gave the thumbs-down signal to what it called the "ad hoc" call by a group of doctors for medical practitioners to close their practices on October 28 and 29.

Masa reaffirmed its opposition to VAT on medical services and said it would continue to make representations for a review of the situation.

But it said it could not support the closing of practices since it would be unethical for doctors to withhold services unless they had ensured alternative care.

The SDFP said it could not support the action since patients and not the Government would be inconvenienced and it was illegal for doctors to strike in terms of the Medical, Dental and Supplementary Health Services Act.

● Cape general practitioners last night backed the strike but resolved that emergency medical cover be retained.

The Western Cape Dispensing Family Practitioners Association agreed to the closure.

The DFPA represent about 350 doctors and claim a patient base of up to three million.

DFPA spokesman Dr Robert Rapiti said "the last resort" action was caused by the Government's unwavering stance on tax on health care services.

Dr Rapiti said the GP's patients would be bused to state medical institutions during the strike.

The DFPA also discussed plans to withold VAT payments on medical services. — Sapa.

Politicians to talk on health

Sowetan Correspondent 25/10/91

POLITICAL parties and extra-parliamentary groups will spell out their views on South Africa's future health care options at a seminar in Pretoria on November 7.

Speakers representing the Democratic Party, National Party, Labour Party, Pan Africanist Congress and trade unions, have already accepted invitations to address the seminar, being organised by the Pharmaceutical Manufacturers' Association of South Africa.

Invitations have also been extended to the African National Congress, Inkatha and Cosatu. The Conservative Party has said it will not be represented.

The seminar, which starts at 8am, will take place at the Piet van der Walt Theatre at the Pretoria Showgrounds.

Hospitals or

C/Pres 27/10/91. (85)

By SOPHIE TEMA

THERE has been a drastic and rapid collapse of health services in black hospitals, according to a discussion document submitted to the ANC at their recent conference.

Appalling conditions in these hospitals are blamed on the brain-drain of medical professionals who have either left the country or joined the private sector.

The authorities' fragmentation of health services was also cited as an important cause of the collapse.

In most black hospitals patients still sleep on the floors and doctors and nurses are unable to cope with the flood of the sick and the dying, says the document.

It says there are so many health departments that it is impossible to plan or co-ordinate health care.

The document states that conditions at Bara and elsewhere are no different to those described four years ago by Bara's retiring chief of medicine, Professor Leo Schamroth. Schamroth called the wards "horrendous, disgusting and despicable".

Soon after Schamroth left, 101 doctors and professors at Bara signed a letter of protest which was published in the South African Medical Journal.

The ANC document says that despite increased fees and the hospital's R8-million budget, there has been no improvement.

It protests the fact that health services in black hospitals are still largely and unequally segregated.

It says: "A history of apartheid, oppression and exploitation has created conditions which have affected the health services. Despite promises made by Government and the repeal of the Separate Amenities Act, there are major differences in access to good health care between black and white, rich and poor, 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

"There are serious problems where the Group Areas Act and forced removals have distorted patterns of settlement."

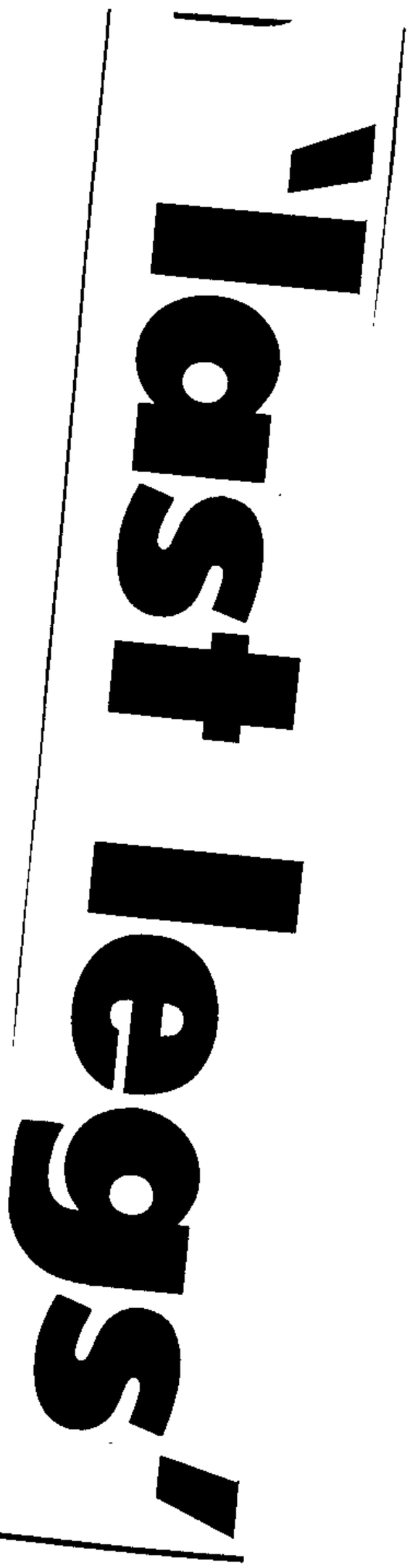
It says about half the money spent on health care is paid to doctors, dentists and pharmacists in the private sector.

The hospitals' share is only a quarter.

Public funds are used for training health workers who drift to the private sector.

Only five percent of state doctors work in the homelands which the document says underlines the fact that the private sector focuses its efforts on those who can pay for treatment – which causes neglect of the task of preventing disease.

The document concludes that a new national health service will have to make use of traditional healers.



Single health service on cards

PRETORIA — National Health and Welfare Minister Rina Venter signalled at the weekend that government was moving towards ending the duplication of health structures created by the own affairs system.

Opening a community health centre in Bedfordview, Venter said the fragmentation of health services had tq be eliminated, but added this would be done within the limitations of the present constitution.

"We cannot afford the present duplication of services. One authority must take full responsibility for a specific service within a defined geographical region."

Based on these principles, it had been decided that all primary health care services should be rendered by local authorities.

GERALD REILLY

Venter said the private sector would be involved in any new health dispensation.

Meanwhile Sapa reports the Public Servants' League (PSL) will meet Venter next month to discuss fears that almost 7 000 Cape health workers could lose their jobs to avert a projected R80m shortfall in the provincial budget.

PSL GM Bernard Wentzel said at the weekend the league, representing more than 50 000 public sector workers "could not accept or approve the fact that the government has decided to privatise and retrench workers", despite assurances by government that this would not happen.

Masterbond men left powerless

Own Correspondent

CAPE TOWN — Masterbond Trust Group directors Koos Jonker and Johan Brits have been stripped of their powers to run the financially troubled company.

This followed an order in the Supreme Court on Friday after an application by the executive officer of the Financial Services Board. B/Day 28/10/91.

Masterbond Trust Investment Holdings was placed under the curatorship of Willem Johannes Wilken, Jozua Francois Malherbe and Arnold Galombik — the same curators of Masterbond Participation Trust Managers appointed earlier last week.

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'Own affairs' health to end

Own Correspondent

PRETORIA — The government is to end the duplication of health structures created by the own affairs system, Health and Welfare Minister Mrs. Rina Venter said at the weekend.

Opening a community health centre in Bedfordview, Mrs Venter said the fragmentation of health services had to be eliminated, but added that this would be done within the limitations of the present constitution.

"One authority must take full responsibility for a specific service within a defined geographical region," she said.

(85) CT 28/10/91

Question mark over 'strike' by private doctors

Star 28/10/91

By Carina le Grange
Medical Reporter

Up to 3 000 private practitioners may today and tomorrow close their surgeries in protest against VAT on medical services — but it is not clear whether the South African Medical and Dental Council would take disciplinary action against what some critics have called a strike.

The health sector of the Co-ordinating Committee on VAT, comprising several health care organisations, last week decided to go ahead with a "voluntary closure" of private doctors' surgeries despite opposition from certain sections within the profession.

Some professional bodies who oppose the action have said it was unethical for doctors to close surgeries or to "strike", and that it may also be illegal.

The Medical Association of SA said it could not support the action, adding it was unethical for doctors to withhold their services unless adequate arrangements had been made for alternative care, as patient care should never be jeopardised.

The Society of Dispensing Family Practitioners said: "It is illegal for doctors to strike in terms of the Medical, Dental and Supplementary Health Services Act and doctors who go on strike could be struck off the roll by the South African Medical and Dental Council."

But the SAMDC made reference to public-sector doctors on strike when approached for comment.

Registrar Nico Prinsloo said the reaction of council president Dr Len Becker was that the Medical Act provided for "a conviction in a court of law (in cases of) medical practitioners who participate in a strike which may disrupt the rendering of a public health service".

Mr Prinsloo said it was only after conviction that the matter would be reported to the council for investigation and possible action.

The doctors who propose action are however in private practice and said their action should be seen as a "protest demonstration" and not a strike. They would also make their services available to State clinics during the closure.

Dr Becker had also said, however, that "every medical practitioner remains personally responsible for his actions" and that he hoped they would not act in any way which would be detrimental to their patients.

Health-education trust to be formed

Staff Reporter (85 ARG 29/10/91

THE Institute of Public Health has announced a health-education trust for Southern Africa to help to uplift underdeveloped communities.

The move, announced in Cape Town last night by institute president Mr Hilton Ryder at the opening of the institute's congress, followed a suggestion from the Department of National Health.

Political changes were developing at an increasing pace, Mr Ryder said. "It's essential that these communities are provided with adequate and appropriate knowledge of the field of public health."

The trust, which would operate as an independent development agency and represent all regional communities, would focus much of its activities on fighting the increase in "preventable" diseases like tuberculosis.

Help would be given to existing organisations such as the South African National Tuberculosis Association (Santa) and would create new mechanisms to educate the public.

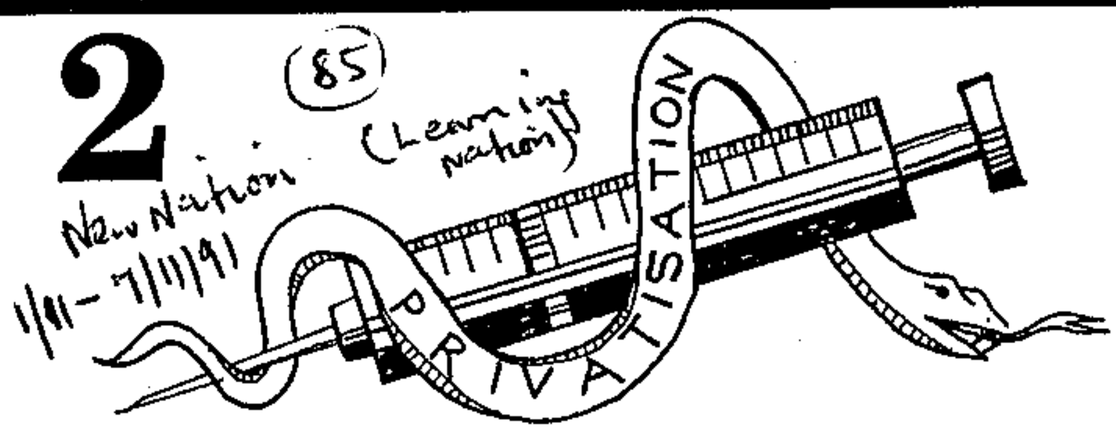
"The co-ordination of resources in the form of manpower knowledge, skills and finance will facilitate and accomplish a great deal more in a shorter period of time."

Mr Ryder said that Aids, specifically an Aids-prevention programme, depended largely on teaching the community about safer sex.

The trust would be particularly concerned with activities which had real community support.

While it would co-ordinate its activities with those of authorities at national, regional and local level, it would take "particular care not to assume the responsibilities of government at any of those levels".

HEALTH 2



In our previous article on Apartheid and health we raised a number of important points about the current health crisis in South Africa. The main areas we looked at were:

- the wastefulness of the apartheid system which swallowed up so much of the health budget in administration because of the duplication caused by having different local and regional services, different structures for the "races" and for the bantustans.
- how privatisation will fragment health services even further and make health mainly for rich people.
- the fact that capitalist pharmaceutical industry is a major cause of the large expense of medicines and medical care.

A National Health Service

In the document:**Towards developing a health policy; Discussion document for the ANC National Conference, June 1991**; it states that "... Health is a basic human right. This right, particularly to free essential health care, should be legally entrenched in the Bill of Rights of the Constitution...."

The first question which is of direct concern to all of us is: can a Bill of Rights guarantee health care to all citizens? The Bill of Rights expresses a need which is not the same thing as guaranteeing whether the need is met. It is only when that need is met in the form of receiving the health care, that the freedom is realised.

This fact has been recognised in the commitment to a **National Health Service** for South Africa in which the state would provide free health services for all. **The Freedom Charter** made this significant commitment:

- A preventative health scheme shall be run by the state
- Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children
- The aged, the orphans, the disabled and the sick shall be cared for by the state.

A National Health Service and the Apartheid State

From the side of the state the responses to the ongoing critical state of public health in South Africa have largely been "paper" ones. Numerous health commissions were appointed but very few of their recommendations were implemented. And even these "paper" responses were made in a period of heightened class activity. The most interesting example of a recommendation from a commission appointed by the state is The Gluckman Commission in 1942 which met in the context of the increased urbanisation of African people and the heightened class struggles during World War Two. The commission reported that health services were "disjointed and haphazard, provincial and parochial", that it was mainly directed not to the promotion and safeguarding of health, but to the cure of ill-health" and that it was not "available to all sections of the people of the Union of South Africa". The commission called for the establishment of a National Health Service in which the service was to be provided free and paid for by a **National Health Tax**.

However the Smuts Government rejected any idea of a free National Health Service. The government refused to do away with the fragmentation of the provinces' control over the hospitals and abandoned the idea of a Health Tax.

In 1980 the Department of Health published a National Plan. It was a plan without clear accountability structures and had no timetable for a plan of action. The plan was not implemented.

In 1986, the Browne Commission of Enquiry noted that "There is an excessive fragmentation of control over the health services and a lack of central policy direction. This has led to a misallocation of resources and wasteful duplication of services."

The above National Plan and the Browne Commission of enquiry occur against the backdrop of virtually uninterrupted class struggles from 1976 onwards. The struggles, compared to all previous struggles, are much wider and deeper. They relate to a wider range of issues including health issues.

These varied from specific trade union demands for maternity benefits, health and safety at workplace to broader demands for community based clinics, to desegregation of health services. In addition, there has been a mushrooming of a variety of health organisations. These range from bodies that unionise health workers (NEHAWU), to those that take up various community-based health campaigns (SAHWCO) and providing services to the unions (WIG).

Privatisation

More recently the state has moved completely away from assuming any responsibility for health care, let alone listening to recommendations for a National Health Service. Instead the state has become committed to **privatisation of health**. The process of privatisation of health care has included a number of aspects, of which the main features are:

- **massive cutbacks** in the building and servicing of state hospitals. In 1991 state hospitals in the Cape were forced to turn away all but extreme emergency cases because of cuts in their budget.
- the increased number of **private hospitals** which are increasingly taking over from state hospitals in both availability and quality of health care
- the increased role that **medical aid** plays in encouraging the use of private doctors and hospitals and in pushing up the cost of medical care.
- the greater role private **pharmacists (chemists)** play in not only issuing medicines, but also in giving diagnoses
- the increase in the number of **patented medicines** sold at supermarkets and commercial outlets which takes the burden off normal hospital dispensaries

Some Views in the Liberation Movement on Free Health Care

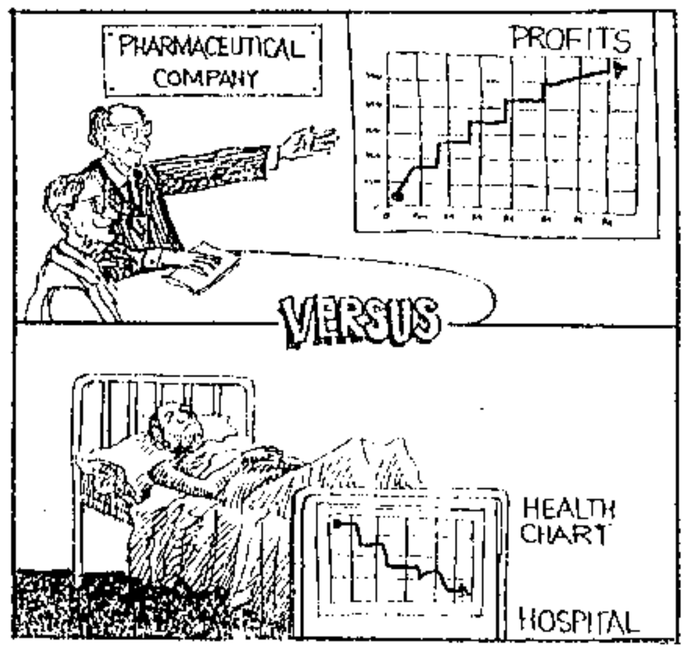
Some people argue that the right to health care must be seen in the context of limitations inherited by post-apartheid government and therefore the demands have to be realistic. For example, not everyone should have the automatic right to a doctor...."Unrealistic demands could create expectations that a future government would not be able to meet".

These people in the liberation movement argue that health policy studies must "ensure that visions of the future are compatible with what the future can offer".

Those who oppose this view argue that the issue here is not the inheritance of the limitations but how a new post-apartheid government is going to organise its economy. One of the main reasons for fighting the existing government structures is precisely to overcome these limitations and not to keep them in place. These people are avoiding the question: will the new South Africa be capitalist or socialist? In fact the limitation thesis does not hold water even if argued within a capitalist economy. **Presently there are vast sums of money locked up in the banks and insurance companies.** The capitalists are holding back this money until there is a favourable investment climate. Furthermore the capitalists are withdrawing capital into overseas investments. There is no reason why this money cannot be utilised for public programmes such as health.

Another debate is the relationship between demands and expectations where some people argue against what they call "unrealistic demands" because, they say, such demands can create unrealisable demands. It implies that "unrealistic" demands are manufactured in some activists' mind, are posed to the masses and thereby raise the expectations of the masses. Others say that this is entirely false. Expectations are created by the stark reality of the bosses or the majority of the whites or the rich who live in fancy houses, drive fancy cars and have access to modern health facilities. It is the expectations realised through the material reality which are concretised into demands. To make expectations "realistic" means in practice asking the masses to tone down the demands and give the state and the bosses a free rein to do what they want to.

What do you think about a National Health Service and free health for all? Do you think this is possible? Where will the money come from?



ANC prepares for election

THE ANC is busy laying the groundwork for a non-racial election campaign, according to ANC spokesman Carl Niehaus.

He said most of the ANC's 900 branches were looking at potential problems associated with fighting such an election.

Niehaus said voter registration would be an enormous task. A massive effort, including an awareness campaign, would have to be made to get all eligible voters onto the roll. Bidvy 6/11/91

Studies had been made of international election procedures and preparations which would ensure the ANC was well prepared when the time came.

A Home Affairs spokesman said there were more than 9-million blacks with ID books — 73% of the projected 12,5-million blacks over the age of 16 in SA.

He said a campaign was needed to get the rest to register.

GERALD REILLY
and DARIUS SANAI

Latest statistics show that at end-September this year there were 5,5-million registered white, coloured and Asian voters. White voters totalled 3,3-million.

Central Statistical Service figures show the number of blacks over 18 is more than double, at 11,5-million.

Political analyst Willem Kleynhans said preparing for black participation in SA's first one-man, one-vote election could take until the end of the century.

He said the current register could be used as a base for compiling an electoral roll for a future non-racial general election, but the matter would have to be resolved by political groups when they finally began negotiations.

Venter calls for new social legislation

PRETORIA — A new approach to social legislation should be considered, Health Minister Rina Venter suggested yesterday.

She told a think-tank on care for the handicapped that existing Acts should be made into one umberella Act with subordinate Acts.

This would facilitate the task of players in the field, since they would no longer have to search through various statutes for appropriate legislation.

Umbrella legislation would form an integrated part of the programmes offered by the welfare system. Bidvy 6/11/91

Venter said that without neglecting the secondary and tertiary services, more funds should be made available for primary services.

"That means stronger focus should be placed on the development of people, families and communities."

At this stage 1,6% of GNP was spent on welfare services. It should, however, be increased to 3,2% and money should be made available to primary social welfare services, especially in underdeveloped communities, she said.

"In a Third World country which is endeavouring to make primary social services available and accessible to all its inhabitants, it is inevitable that both government and the private sector will bear a heavy financial burden."

She said an aspect that needed attention was that people who could afford social services should be made to pay. — Sapa.

ANC foresees control over private heath

Star 8/11/91

By Carina le Grange
Medical Reporter

The ANC envisages a future health service in which the private sector would be accountable to the Government and in which funds would be redistributed from the private to the public sector in a comprehensive national health service, Dr Aslam Dasoo of the ANC's health department has said.

He was speaking in Pretoria yesterday at a seminar organised by the Pharmaceutical Manufacturers' Association.

Incorporated

Other speakers included representatives of the National Party, the Pan Africanist Congress, the Democratic Party and Inkatha Freedom Party.

The private sector would in the long term become incorporated into the national health service "so that it becomes accountable to, and is under the overall control of, the Government", Dr Dasoo said.

"In re-organising the health services, the Government will aim to attract staff and to absorb a major section of the private sector."

He said the ANC did not intend to nationalise the private health sector, and the fact that the ANC believed there should be some control of this sector implied that the organisation accepted its existence.

Dr Dasoo said the private sector thrived at the expense of the public sector in matters such as the training of personnel, on which it drew heavily without giving anything back.

Earlier, he had characterised the present health care system as "an obscene perversion" in which the majority of people had been "subjected to one of the most bizarre, inhuman and unjust sytems ever devised ... which is still perpetrated".

Apart from the redistribution of funds from the private to the public to finance the service, other people would contribute through taxation or contributions to the national health fund.

The ANC also proposed to establish a national medicines policy to deal with availability, distribution and pricing.

Fund open to all miners

B\Day 8\11\91

THE Chamber of Mines' legal victory to open a mining industry pension fund to employees of all races was a tangible demonstration of its commitment to nonracialism, the Chamber said yesterday.

Earlier, the Chief Justice rejected a petition by the Council of Mining Unions to appeal to the Appellate Division against a judgment by the Labour Appeal Court in favour of the Chamber.

The Appellate Court's decision upholds a ruling by the Labour Appeal Court and the Industrial Court that the CMU's objection to the admission of blacks, Asians and coloureds as employee members of the Mine Employees' Pension Fund was an unfair labour practice.

Chamber president T I Steenkamp said the ruling by the Chief Justice was an important and welcome event.

Steenkamp said the practical effect of the Chief Justice's decision was that people of colour who occupied positions at a particular level and who had previously been excluded from joining the MEPF on the basis of race would now qualify for membership. — Sapa.

ANC policy on medicine

B\Day 8\11\91 (85)

GERALD REILLY

PRETORIA — An ANC government would incorporate major sections of the medical private sector into a national health service under government control, ANC health spokesman Dr Aslam Dassoo said yesterday.

Dassoo told a Pharmaceutical Manufacturers' Association of SA conference that in reorganising health services the ANC would aim to provide health care through an improved and strengthened public service accountable to the communities it served.

The public sector health service would attempt to attract staff and to absorb major sections of the private sector. It had to be accepted that the health care system in SA was an obscene perversion which needed replacing, not reforming, he said.

Dassoo, an executive member of the SA Health Workers' Congress, said the right to free health care should be legally entrenched in a future bill of rights and that there had to be a preferential allocation of resources to promote health care within the most vulnerable sectors of the community.

The ANC would strive for a nonracial, single national health system for all. All health services would have to be the responsibility of a single authority.

Viljoen challenges PAC

B\Day 8\11\91

Business Day Reporter

GOVERNMENT yesterday called on the PAC to clarify its position on the armed struggle.

Constitutional Development Minister Gerrit Viljoen said the PAC's armed struggle was "cause for serious concern".

Viljoen was reacting to a claim by PAC Harare spokesman Victor Phama that the PAC's armed wing, the Azanian People's Liberation Army (Apla), was responsible for a weekend attack in Soweto that killed SAP member Martin van Wyk and injured his colleague M M Tuge.

The PAC also claimed responsibility for killing two policeman at Katlehong on the East Rand recently.

Viljoen said in reply to the attacks: "Any organisation acknowledging responsibility for continuing armed action and for assassinations is very seriously imperiling its own involvement in genuine and peaceful negotiations."

MRC launches first study on rural trauma

Staff Reporter

MORE than 36% of the potential years of life lost in 1984 was due to premature deaths in South Africa from non-natural causes, according to the Medical Research Council (MRC).

This was revealed when the council launcheda study — the first of its kind — on trauma, called Rural Injury Surveillance System (RISS), which will monitor all types of trauma in rural areas.

Headed by the MRC's National Trauma Research Programme, the project will involve over 30 researchers and health-care workers, and will serve over 700 000 people in the Western Cape. The study's co-ordinator, Dr Blanche de Wet, said SA needed to plan effectively for trauma prevention.

The project, which will take place over a year, will process data continuously and provide processed information back to participating hospitals and regional authorities. The initial phase will involve hospitals at Caledon, Hermanus, Montagu, Robertson and Somerset West and other areas.

First line of defence should be DIY care

SELF-MEDICATION must be allowed to become the first line of health care, backed up by professional care with prescription medicines.

"Governments, however affluent, cannot continue to accept full financial responsibility for good health," Chris Rose, president of the Proprietary Association of SA, told delegates to the Pharmaceutical Manufacturers' Association last week.

"Self-medication forms an integral part of every health care delivery system world-wide.

"In developed countries, it is aimed at reducing the formal health care delivery service costs, and in developing countries it fills the gap created by the non-existence of a formal health care delivery service.

"Both circumstances prevail in SA, making self-medication even more pertinent to any health care delivery strategy."

He said South Africans across the full spectrum had demonstrated their ability to use off-the-shelf medications responsibly.

The Government had allowed this trend to develop by transferring proven prescription drugs to non-prescription status, he says, but the private sector also had a role to play.

"Doctors, pharmacists and others need to focus more closely on the benefits of self-care."

Mr Rose also called for more readable, user-friendly package and insert design.

"The consumer must be able to recognise the symptoms for which self-medication is appropriate, choose products which will alleviate those symptoms, and administer the correct medicines in the correct dosage for the correct period of time," he said.

At the same time, he said, self-medication products should be available through as many purchase points as possible.

Although the pharmacist should remain the key distributor, he said supermarkets and other outlets should be free to sell proprietary medicines with a proven safety profile.

Duplication of health services 'must end'

85

PRETORIA. — Fragmentation of health services had to be eliminated as far as possible because the country could not afford the duplication, National Health and Welfare Minister Dr Rina Venter said in Durban at the weekend.

She said South Africa was currently spending 6,4% of GNP on health services and that 80% of the population depended on the state for services.

Speaking at a meeting of the Co-ordinating Council of Local Authorities, Dr Venter said South Africa's present health dispensation was not the answer because services were unaffordable. CT 18/11/91

Public health service 'too fragmented'

GERALD REILLY

PRETORIA — Fragmentation of health services had to be eliminated as far as possible because the country could not afford the duplication, National Health and Welfare Minister Rina Venter said in Durban at the weekend.

She said SA was currently spending 6,4% of GNP on health services and that 80% of the population depended on the state for services.

Speaking at a meeting of the Co-ordinating Council of Local Authorities, Venter said SA's present health dispensation was not the answer because services were not affordable. They were also inaccessible to large sections of the community.

She believed services would have to be rendered at the lowest level of government.

Centralisation of executive functions had to be avoided and, within the limitations of the present constitution, fragmentation had to be eliminated.

Cabinet had accepted that all primary health care services would be rendered by local authorities.

Chamber of Business joins call for health care revamp

VIVIEN HORLER
Medical Reporter

THE county's largest representative body of employers, the South African Chamber of Business, has joined the call for a new comprehensive health care system that is efficient, affordable and fair.

The chamber says it is "imperative" that such a system be created.

It said private patients faced the danger of being unable to afford private health care, and at the same time State health services "have deteriorated markedly".

In a position paper on the health care crisis published in the Cape Town Chamber of Commerce's weekly bulletin, Sacob says: "There is an increasing demand for business to address the efficiency of social service delivery systems.

"Demands are made on individual employers to provide increasing social benefits, including health care, as part of conditions of service."

Sacob has drawn up a list of principles which it believes should be incorporated in a new health care system. They include:

- Actively promoting the dismantling of health care apartheid and the replacement of South Africa's various health departments with a unified department and a uniform countrywide policy.
- Dedication to equity, which will mean deregulation and intervention "in the vested interests which are preventing restructuring of services and cost containment".
- A system which enables private and State health care to exist, with provision for a close working relationship between the two sectors.
- A new health care delivery system whose aim will be good basic health care for all, and will include the preventive and curative approach.

SATV 'censors' Boesak video

South 21/11 - 27/11/91 (88) (85) (2)

By Heather Robertson

TELEVISION producer Ms Elna Boesak has lashed out at the SABC for allegedly censoring an in-depth documentary on the crisis at Tygerberg Hospital.

She has also accused the SABC of bias towards Minister of Health Dr Rina Venter in the programme screened this week

"I distance myself from the superficial manner in which Agenda handled the serious problems at academic hospitals," said Boesak.

"This action can be interpreted as nothing less than the protection of the Minister of Health. I want to personally apologise to all the staff and patients at academic hospitals."

Boesak's original 25-minute documentary included interviews with a dozen medical personnel and the dean of the University of Stellenbosch medical faculty who warned of a looming catastrophe at the hospital.

Details which were not screened included controversy over a million rand cut in the expansion of the hospital since the beginning of the year, the freezing of posts, cutbacks on beds, the use of outmoded equipment in life-and-death situations and the turning away of seriously sick patients.

Boesak said the eventual broadcast of five minutes of the 25-minute programme followed by an interview with Dr Rina Venter was screened without informing her as producer of the programme.

According to Boesak, the editor of Agenda had agreed that the programme would be cut to 15 minutes followed by a debate between the minister and representatives of medical schools in South Africa.

CENSORED: Ms Elna Boesak in dispute with the SABC

"I find the manner in which Agenda glibly brushed over these serious problems totally unacceptable," said Boesak.

Mr Johan Pretorius, editor-in-chief of Agenda, said the SABC wanted to make doubly sure of all the facts before responding to Boesak's claims. He said the SABC regarded the matter in a serious light.

"If necessary we may have to implement our internal personnel regulations on the basis of our disciplinary code," he said with obvious reference to Boesak's public criticism of the SABC.

Health care comes on too strong — study

Southside 21/11 - 27/11/91. (85)

WHILE HOSPITAL facilities are desperately limited, available medical care resources are not being used in the most effective way. This is the finding of researchers at the Medical Research Council (MRC).

The research found high-level health care facilities are being used by patients who do not need them.

Researchers believe over half the days patients spent in a ward at a large academic hospital in Cape Town could have been spent receiving cheaper and less sophisticated but equally effective care.

The study, in the latest South African Medical Journal, showed nurses spent too much time attending patients who could have been treated at lower levels.

The aim of the study was to determine levels of care necessary as opposed to the amount of professional care provided.

The researchers also tried to estimate how much of the tertiary hospital's resources were being expended on patients who required lower-level care facilities.

Of the total number of patient days (the days every patient spent in the hospital), 54,5 percent could have been spent at a lower level of care, researchers found.

They said 27 percent of patient days could have been spent in a hospital that did not have full-time specialist care, while 20 percent could have been spent in a convalescent hospital with patients seeing a doctor only once every two or three days.

Home care would have been appropriate for 6,8 percent of patient days.

Dr Merrick Zwarenstein, the project's principal investigator, said health care could be provided more economically if more lower-level facilities — primary health care clinics or non-specialist hospitals — were available.

"To lighten the load for our specialist hospitals, primary health care facilities should be expanded and referral patterns improved," said Dr Zwarenstein.

"The plight of South Africa's public sector hospitals has been highlighted in the media over the last year. We must plan for and develop the necessary community health infrastructure if we hope to preserve our sophisticated tertiary health services.

"We must provide appropriate, affordable, quality health care which is accessible to the community."

He said work was necessary to confirm the findings at other hospitals, and a national plan needed to be formulated so that all hospitals and health care resources were used in a cost-effective, coordinated way. □

NEWS IN BRIEF

B/Day 22/11/91

Rina 'should resign'

THE Natal Provincial Administration Staff Association in Maritzburg yesterday called for the resignation of National Health Minister Rina Venter. (85)

In a resolution it accused her of "irresponsible, inconsiderate and unprofessional" handling of the health crisis in Natal, particularly the ambulance services.

VAT virus is infecting the medical profession

w\mail 22\11\-28\11\91.. 85

The continuing controversy over Value-Added Tax is dividing Masa, the country's biggest organisation representing the medical profession, reports **RAY NXUMALO**

WHEN finance minister Barend du Plessis sneezed last month, the whole country caught a cold — but the worst affected was the medical fraternity.

And the doctors seem unable to cure the malaise of VAT on medical services and supplies. Now their representative body, the Medical Association of South Africa, is about to catch the virus.

The VAT crisis has cracked the organisation into factions and created conflicts among doctors. "Dissident" doctors are now urging their colleagues to quit Masa due to its failure to have medical services re-rated.

Masa openly rejected VAT, but it preferred not to take any action — like supporting members who wanted to close surgeries and take to the streets.

Masa's present policy is "to continue to follow the planned process of consultation, and obtain a commitment from government to review its decision about VAT on medical service within six months".

Therein lies the problem. A section of the membership did take to the streets last month — to the dismay of Masa, which felt that type of action was unethical and unprofessional.

Says Dr Kishore Deva, a doctor who took part in the street protests, "We can't wait for March while our patients are dying of TB."

Masa's policy has disillusioned many doctors who are opposed to VAT on medical care and basic foodstuffs. And they claim that some of the VAT-related decisions Masa has taken were not first put to members.

"I am a member of Masa, but I find it strange that my opinion on the imposition of VAT was never canvassed," Deva said.

He says that the actions of the association are the opposite of what it claims to stand for. Further, the "dissident" doctors feel that the association has not done enough to address apartheid. Masa's federal council is composed of 44 members — all of them white.

Federal council chairman Bernard Mandell announced on Tuesday that, "In order to broaden its representation, Masa's federal council has been doubled to afford more doctors the opportunity of taking leaderhip positions with Masa.

"The association has also made every effort to involve other key role players in health, in their individual capacities and through their organisations, in the many vital issues which are currently being addressed, such as the dispensing of medicines, future health policy, the treatment of hunger strikers, registration of medical doctors with foreign qualifications who wished to return to South Africa."

However, this will not be enough to mollify the "dissidents".

"We refuse to be used by the government as its tax collector," said Dr Joe Maelane. "Our main concern is the plight of the patient who is going to be taxed for being ill."

Many of the "dissident" doctors feel Masa is not representing their interests and they are seriously considering pulling out of the organisation.

Mandel does not believe their call is justified.

"The biggest challenge for the medical profession is to achieve equitable healthcare for all in South Africa. By displaying a spirit of positive criticism, and not condemnation, a strong sense of purpose has developed among Masa members," he said.

Mandel reiterated Masa's opposition to VAT on medical services, and its commitment to continue pressing for a zero-rating.

"Although strategies to convince the government of the detrimental effects of VAT on medical services differed, the medical profession shared the common goal of working towards its abolishment.

"The relief measures announced by government so far are aimed at addressing some of the concerns raised by Masa but are believed to be inadequate to overcome the negative consequences of VAT on health care.

"In particular the fact that only public health services had been exempted from VAT is regarded as blatant discrimination against patients treated in the private sector, and Masa is currently awaiting feedback from the minister of finance on a request that this decision be reviewed before the end of March," he said

Nevertheless, the "dissident" doctors think this is just a lip service.

They have promised to forfeit the proposed 16 percent increase of medical tariffs for 1992 if Du Plessis zero-rates VAT on health care.

A pre-condition attached to this undertaking is that medical schemes decrease their members' monthly subscription. This would effectively pass the benefit on to the patients, and not the medical schemes.

August 1991

SA's first private blood bank now open

B\Day 22/11/91.

DAVE LOURENS

SOUTH Africans concerned about the health risks associated with blood transfusions can now build up their own deposits.

The Private Blood Bank of SA was established this month to provide an "autologous" blood service. An autologous transfusion involves the collection and reinfusion of a patient's blood.

Blood Bank MD Malcolm Macdonald said the company had been inundated with calls from the public and surgeons.

"The bulk of our market is elective surgery. Most surgeons say they would prefer to reinfuse their patients' blood. This reduces the chances of incompatibility or rejection."

This would rule out the possibility of contracting AIDS and other diseases, although Macdonald said none of his prospective clients had cited AIDS.

"I do not think AIDS can be contracted from a transfusion in this country. We have the best transfusion service in Africa."

The Private Blood Bank charges R160 per 450ml unit of blood for the first nine months. Thereafter storage is R60 a year.

The bank's advanced technology allows blood to be preserved for up to five years instead of the usual 35 days.

"In 90% of cases a patient would not require more than five units of blood during surgery. A healthy person can donate about three or four units a month," said Macdonald.

The bank, operated by 22 staff members, has sufficient storage capacity for 45 000 units. The service is only available in Johannesburg, but it is planned to expand to Cape Town in January and to Durban in March.

First National Corpora
and/or their renounce
representing 99,55%

The underwriter, Gen
rights.

Johannesburg
22 November 1991

Cabinet 'blocked health reform'

By BARRY STREEK

THE cabinet had blocked plans by the Minister of National Health, Dr Rina Venter, to reform South Africa's health care system, Democratic Party health spokesman Mr Mike Ellis said yesterday.

In Pretoria, Dr Venter dismissed calls for her resignation, saying she accepted that unpopular steps had to be taken for the implementation of a national health plan.

She regretted that Masa had made use of the media instead of contacting her directly.

Mr [illegible]s and Dr Venter were reacting to calls for Dr Venter's resignation by the Medical Association of South Africa and the National Medical and Dental Association.

In a statement, issued by its secretary-general, Dr Hendrik Hanekom, Masa expressed a vote of no-confidence in Dr Venter and said it was deeply concerned about Dr Venter's inability to display strong leadership and take appropriate action in resolving critical issues facing health care.

Mr Ellis said Dr Venter had "brought a new vision into health care", although "much of the promise she started with has not been fulfilled".

To blame her directly might be "a little unfair" since the cabinet had "blocked some of her initiatives in the past".

She had also been "badly advised by the bureaucrats around her", and this had not boosted her image among those for whom she was responsible.

Medical bodies call on Venter to quit

DAVE LOURENS (85)

THE Medical Association of SA (Masa) and the National Medical and Dental Association (Namda) called yesterday for the resignation of National Health Minister Dr Rina Venter. B|Day 29/11/91

While Namda has opposed government on numerous issues, the 12 000-member Masa is generally considered to enjoy a close relationship with health authorities.

Masa secretary-general Dr Hendrik Hanekom said Masa wanted Venter to step down because it was "deeply concerned" about her inability to display strong leadership and take appropriate action to resolve critical health-care issues.

Venter yesterday blamed the attack on proposed amendments to the Medical Schemes Act, but said amending the Act was essential to ensure a more affordable medical service to the public.

The Masa statement, issued by its federal council chairman Dr Bernard Mandell, said the fact that the parties at the conference on medical schemes could not reach consensus on proposals was a warning to Venter not to go ahead with amendments to the Act. B|Day 29/11/91

Representative Association of Medical Schemes executive director Rob Speedie said he believed the proposed amendments were vital. "We have to have these changes, and if the Minister is determined to go ahead with them she has our full support."

☐ To Page 2

☐ From Page 1

Venter B|Day 29/11/91 (85)

Medical scheme administrators earlier this week warned that unless changes were made to the Act, medical aid subscriptions could rise by up to 40% next year.

Mandell said insufficient progress had been made during the past two years to improve the health situation.

Priority problem areas included the VAT zero rating of medical services, the deterioration of academic medicine and public health services, and the fragmentation and segregation of health services.

Masa representations to Finance Minister Barend du Plessis that all medical services be zero rated had received virtually no support from Venter.

Namda director Dr David Green said they supported Masa's call. "We call on the Department of Health to call a moratorium on all new legislation and enter into a process of bona fide negotiation with all interested parties. Health care cannot wait for a greater political settlement."

Growing chorus for the head of Health Minister

STAR 29/11/91

(85)

By Helen Grange
Mckeed Kotlolo and Sapa

There was a growing chorus yesterday for the immediate resignation of Health Minister Dr Rina Venter, amid warnings that the country's health services were on the brink of "total disaster".

Despite urgent calls by at least two prominent medical organisations and other bodies for her resignation, Dr Venter committed her department to proceeding with the "satisfactory" new health plan.

The Medical Association of South Africa (Masa) and the National Medical and Dental Association (Namda) made the demand "because of Dr Venter's inability to display strong leadership or address critical issues".

Proceed

The SA Dispensing Practitioners, Women for Justice, the Freedom Foundation and the Aids Coalition to Unleash Power ("Act Up"), also joined the call.

Dr Venter said in a statement it was in the national interest to "proceed with the implementation of (the) plan in an orderly fashion".

She said she regretted that Masa — the first to openly state its vote of no confidence in her — had "made use of the media" regarding its criticisms instead of contacting her directly.

She was not prepared to communicate with the medical organisations via the media.

Dr Venter said Masa had not at any stage contacted the Minister's office to discuss the issue. She, however, conceded that an amendment to the Medical Schemes Act "is essential to ensure a more affordable medical service to the public".

Forging on . . . Dr Venter says she is proceeding with her "satisfactory" new health plan.

"The inputs of Masa regarding the Act were discussed at the forum on November 25. The Minister is still waiting for the report of this forum," the statement read. It was also conceded that "unpopular steps must be taken" to implement the new health strategy, but that its progress was "satisfactory".

Masa, in a statement issued by chairman of the association's federal council Dr Bernard Mandell, accused Dr Venter of a lack of leadership, vision and insight and a failure to address the country's health problems.

Masa also criticised her for not taking up the issue of VAT on medical services. VAT had had a negative impact on the affordability of health care.

Namda director Dr David Green said yesterday that health services were in danger of collapsing.

Masa calls on Venter to quit

W/Mail 29/11/- 5/12/91 (85)

By RAY NXUMALO

BY CALLING for the resignation of Health Minister Dr Rina Venter, the Medical Association of South Africa has healed its rift with doctors who had felt the organisation had not responded adequately to the VAT issue.

Masa yesterday slammed the minister for lack of leadership, vision and insight.

"Virtually no support came from the minister of national health for Masa's representations to the minister of finance that all medical services be zero rated," it said in a statement.

Dissident doctors who had threatened to leave Masa as a result of its failure to support a two-day doctor's strike against VAT, appear to be climbing down as a result of the resignation call.

"It was a drastic thing for Masa to do," says Dr Kishore Deva, who had taken part in the street protests against VAT. "It is certainly aimed at mollifying the doctors."

Masa has also registered its objection to the deterioration of academic medicine and public health services caused by unsatisfactory conditions in provincial clinics and hospitals. Salaries, outdated equipment and lack of adequate incentives has caused an outflow of qualified personnel, Masa alleged.

A vote of no-confidence in Venter has been echoed by various other medical bodies. National Medical and Dental Association (Namda) and the South African Dispensing Practitioners (SADP) — who do not want Venter to sink alone — have supported Masa's call.

In a supporting statement, the SADP charged that Department of Health and Population director Dr Coen Slabber "must resign his position immediately for the same reason as those of Dr Rina Venter as they are both not competent to handle the rapidly deteriorating health care delivery systems in the country".

A source of even greater concern is the unilateral decisions by the Department of Health. The Draft Bill of the Amendment of the Medical Aid Schemes Act is alleged to have been drawn up by the Representatives Associations of Medical Schemes without consulting people in the medical profession or other organisations that represent public interest.

250 000 abortions done illegally in SA a year

(85) ARG 2/12/91

ZINGISA MKKHUMA

The Argus Correspondent

JOHANNESBURG. — At least 250 000 illegal abortions are performed in South Africa each year — and according to the Abortion Reform Action Group (Arag) the booming backstreet abortion "industry" claims many lives, with the toll especially high in rural areas where access to medical facilities is minimal.

A spokeswoman for Arag, Dr M Diyer, said while many lives were lost as a result of illegal abortions, some "backstreet abortionists" in urban areas were becoming sophisticated and performed "operations" in such a way that many women did not end up in hospital.

Dr Diyer said whatever the numbers were, black women suffered great physical, mental and psychological harm.

"Poverty and desperation also contribute to high incidents of infanticide. It is quite common to find babies in plastic bags and others dumped in rubbish dumps.

"The government is spending a lot of money treating the after-effects instead of legalising abortion and minimising the risks. Some women spend long periods in hospitals suffering from kidney failure and infections," Dr Diyer said.

Dr James McIntyre of the Department of Obstetrics and Gynaecology at Baragwanath Hospital said more than 30 percent of women who have backstreet abortions suffer from sterility as a result of infections.

Health groups reject new Act

Sowetan 2/12/91

85

THE National Medical and Dental Association and the Dispensing Family Practitioners Association have rejected the new Medical Schemes Amendment Act.

implement the Bill.

"We recognise (in the Act) a desperate measure intended to save the imperilled medical schemes industry," Namda and DFPA said in a joint statement at the weekend.

This followed a meeting between them at the University of Cape Town on Friday.

I itis ieclear the medical schemes industry is in a crisis and they are facing an urgent need to economise on spiralling expenses.

The new Bill, however, would have serious repercussions for both providers of health care and for patients - the majority of which will adversely affect health care currently available to many of South Africa's poorest citizens.

The two organisations said the Bill would result in the introduction of extended privatised health care in the form of Health Maintenance Organisations and the expanded involvement of insurance companies in health care.

"The Bill will also have repercussions on our already overburdened public sector health services, by forcing those patients with chronic illness or disability onto State hospitals, and placing greater demands on State services to pick up the

They have also called for the immediate suspension of any further moves to

health needs of those likely to be jettisoned by the new-look medical schemes," the statement said.

The changes, they said, would add up to a badly-planned attempt to restructure the health care arena and this will have far-reaching implications for a future health service in South Africa.

"This has all been done without adequate consultation with those parties affected by the changes.

"We reject such attempts to force inadequate solutions onto the health services.

"In line with the approach to negotiations over the political and constitutional future of South Africa, we insist on a moratorium on all legislation that seeks to restructure the South African health sector by stealth," the statement said.

The government's approach to dealing with the crisis has demonstrated its inability to appreciate the importance of democratic participation in the formulation of health policy. It reflects a lack of concern for the health needs of South Africa's people.

Namda and DFPA called on the progressive health sector and mass-based organisations to oppose the Bill's implementation until thorough consultation had taken place.- Sapa

AFRICA

Elna Boesak ... watered down.

'Message edited out' of Elna's TV film

APG 3/12/91

VIVIEN HORLER
Medical Reporter

THE dean of medicine at the University of Stellenbosch and other senior faculty members have come out in strong support of the claim by television journalist Mrs Elna Boesak that a documentary she made was cut to protect the Minister of Health.

Now the dean, Professor H P Wasserman, who said the cut version distorted and biased a balanced account, has added his voice to calls for the documentary on the crisis in academic medicine to be screened in full.

Mrs Boesak's angry complaints to the Press that the documentary had been "watered down to insignificance" led to her landing on the carpet before an SABC disiplinary hearing yesterday.

She says the programme was "deliberately structured to protect and support the Minister of Health, Dr Rina Venter".

The SABC claims she broke personnel regulations by taking her complaints to the Press.

Two Stellenbosch professors who took part in the making of the documentary, Professor Wynand van der Merwe of anaesthesiology and Professor Thinus de Kock of urology, gave evidence at the hearing yesterday.

Today Professor Wasserman, dean of medicine at Stellenbosch and Tygerberg Hospital, who submitted an affidavit to the SABC disciplinary committee, claimed the editing of the film had served to distort and bias the message.

"A good documentary was suppressed and presented out of context.

"I don't know why this was done. Guessing, I would say the documentary could have been an embarrassment to the government or the Department of Health by showing the conditions under which academic hospitals are operating.

"There is no reason why it should not be broadcast in full. By taking only five minutes in bits here and there and showing them out of context, you distort the whole message and end up with a biased story, out of context and irrelevant.

"You need to see the whole story to get the message. In this case the message was edited out."

Professor Wasserman said he and colleagues had agreed to co-operate with Mrs Boesak in the making of the documentary on condition they were given a preview before it was aired.

Later he and senior colleagues were shown the full 25-minute documentary, which they judged to be "a balanced and fair account of the crisis in academic medicine".

● Professor De Kock told The Argus: "We can't be drawn into the personal argument between Mrs Boesak and the SABC. We can only say that we took part in the making of a film which dealt with academic medicine and we saw and approved the finished documentary, but that the documentary as it was finally screened did not reflect the truth.

"From this we deduce that the SABC was trying to protect the government, and, by extension, Dr Venter who is a member of the government."

The hearing, which is closed to the public and Press, continues today.

Two profs support Boesak

ct 3/12/91

'Programme cut to protect the minister of health'

By BRONWYN DAVIDS

TWO Cape professors yesterday supported television producer Mrs Elna Boesak in a SABC disciplinary hearing into allegations that she broke personnel regulations by criticising the SABC.

The SABC alleges that she broke personnel regulations by criticising the corporation in the press for cutting to shreds her documentary on the "life threatening" crisis facing academic hospitals.

Professor W L van der Merwe and Professor M L S de Kock, of Tygerberg Hospital and the University of Stellenbosch Medical Faculty, supported Mrs Boesak's view that the programme was "deliberately structured to protect and support the Minister of Health, Dr Rina Venter".

Prof Van der Merwe said Tygerberg Hospital academics were "unhappy" with the way the documentary had been robbed of its essence during the 4½-minute screening on Agenda.

Mrs Boesak had shown the academics a 25-minute edited version of her in-depth documentary which had been a "balanced view of the current problems at academic hospitals".

"We don't know what motivated the SABC to shorten the programme, but the feeling among academics is that we support Mrs Boesak's view that the programme was restructured to support the minister of health and protect her stand on academic hospitals," said Prof Van der Merwe.

Mrs Boesak, the wife of ANC Western Cape chairman Dr Allan Boesak, was accompanied to the SABC building in Sea Point by her lawyer Mr Bashier Waglay, her advocate Mr Denzil Potgieter and the national organiser of the SA Union of Journalists (SAUJ) Ms Karen Stander.

Mr Waglay said: "Sadly Mrs Boesak was not allowed legal representation. We were not allowed to sit in on the hearing.

"We believe that it is an important matter and Mrs Boesak should have been allowed legal representation."

Ms Stander, who attended the hearing, said: "Mrs Boesak is not in a position to comment. Fundamental issues, such as freedom of expression and credibility, have been debated."

She said the hearing will continue today.

A three-man delegation from the SABC in Johannesburg declined to comment on the hearing.

TAKING A STAND . . . SABC television producer Mrs Elna Boesak, who is on three months' maternity leave, outside the SABC building in Sea Point after attending a disciplinary hearing.

Picture: BENNY GOOL

Medical bodies unite against Bill

STAR 3/12/91 (85)

By Carina le Grange
Medical Reporter

The National Medical and Dental Association and the Dispensing Family Practitioners Association at the weekend added their voices to others in the medical profession rejecting the amendments to the Medical Schemes Act.

Namda and the DFPA also called for the immediate suspension of the Bill's implementation.

In joining the Medical Association of South Africa (Masa), they further fuelled the controversy around the proposed amendments, and put doctors and the medical schemes industry on a collision course.

The Representative Association of Medical Schemes (Rams) last week gave its unequivocal support for the proposed amendments to the Bill and came out in support of Health Minister Dr Rina Venter.

Masa last week triggered controversy around Dr Venter when it called for her resignation, accusing her of "lacking leadership and failure to take appropriate action in solving critical issues".

Masa earlier rejected amendments to the legislation "in their entirety".

Rams executive director Rob Speedie said the amendments were vital for the good health and continuance of the country's medical schemes.

He said the debate over the Act had been going on since 1987 and that all interested parties had had more than adequate opportunities to express their views.

However, Masa argued that not enough time had been allowed for comment.

It said the amendments afforded medical schemes unlimited monopolistic powers over the use of services.

Namda and the DFPA said the Bill would force patients with chronic illness or disability on to State hospitals and place greater demands on State services to pick up the health needs of those likely to be jettisoned by the "new-look medical schemes".

Nursing body defends Venter

Sowetan 4/12/91 (85)

Sowetan Correspondent

IT was "naïve" to hold Dr Rina Venter, Minister of National Health, personally responsible for the state of health care in South Africa, the South African Nursing Association has said.

Reacting to calls made last week for Venter's resignation, Sana said in a statement yesterday that problems with the provision of health services were the result of earlier policy decisions, rapid population growth and the poor economic climate.

"It is therefore naive to hold the Minister of National Health personally responsible.

"There are various roleplayers, politicians, officials, individual practitioners, organisations, and even the patient/public, each with a responsibility, who must come forward and accept joint responsibility. No party is totally without blame."

Nonetheless, there were serious problems for which solutions had to be found, and the organised nursing profession could make a substantial contribution at the level of policy formulation.

The Medical Association of South Africa, which last Thursday called for Venter's immediate resignation, held talks with Venter in Pretoria yesterday.

In a statement, Masa said the three-hour meeting was convened at Venter's request, and that a second meeting with her would be held next Wednesday.

Masa did not reveal the subject of yesterday's talks and Venter was not available for comment.

Much of the criticism of Venter has been aimed at proposed changes to the Medical Schemes Act, while Masa has also accused Venter of lacking leadership and of failing to take appropriate action to solve critical issues facing health care.

News in Brief

Pregnancy deaths

(85 CT 5/12/91

GENEVA. — More than 500 000 women around the world die each year during pregnancy or childbirth, nearly half of them in southern Asia, the World Health Organisation said yesterday.

Rina Venter

More calls on Venter to quit

South 5/12 - 11/12/91.

By Quentin Wilson (85)

ANOTHER call has been made for Dr Rina Venter, Minister of Health, and her assistant Dr Coen Slabber to resign.

The call was made this week by the Dispensing Family Practitioners' Association.

They claimed Venter and Slabber were "totally incompetent in handling the important portfolio of health. Their action is not only high-handed but extremely reckless."

The Medical Association of South Africa called for their resignation following amendments to the Medical Schemes Act of 1967. The amendments allow medical schemes to open up health maintenance organisations.

The chairperson of the Practitioners' Association, Dr Robert Rapiti, said "there is a very real danger that a number of doctors would be left unemployed".

He said: "The government should earnestly look at a future health system involving all the relevant bodies that will cater for the health care needs of the entire country."

The Ministry of Health declined to comment.

Rina Venter stomps on some powerful toes

W/Mail 6/12 - 12/12/91. (85)

Until recently, Minister of Health Rina Venter seemed to command healthy respect within the medical profession. Now they are calling for her resignation. Why?

By RAYMOND NXUMALO and PAT SIDLEY

RINA VENTER was never hailed as a visionary or exalted for her power to turn government health policy on its head. But she was, until recently, regarded as a more responsive National Party minister of health than the country had been treated to in the past. She was seen as one of the few Nats who could understand the rhetoric of progressive health interests, even if she did not manage to implement them all.

In the past fortnight, however, she has found several powerful sections of the health sector calling for her resignation.

The "landed gentry" of the medical professionals, the Medical Association of South Africa, called loudly for her resignation, citing her "lack of vision, insight and leadership" and her lack of support for doctors on the question of Value-Added Tax. Masa was joined by the dispensing doctors and then, surprisingly, the progressive National Medical and Dental Association (Namda).

Those shouting loudest and hardest — Masa — have themselves been under fire over the years for their silence in the face of allegations of corruption in the health ministry. They have never been vociferous or vigorous in their calls for the resignation of Venter's predecessors.

What has happened to change the odds so suddenly?

The row broke over a seminar at which amendments to the Medical Schemes Act were being discussed. The major beneficiaries of the amendments, will be the medical aid schemes, currently suffering huge losses as medical costs soar. Allegations of carelessness, extravagant use of the schemes, corruption, abuses and fraud are being laid at the feet of hospitals and doctors.

The major losers — apart from patients — after the amendments become law will be doctors contracted into the medical schemes and those making use of their benefits. The most contentious clause will remove the doctors' automatic right to be reimbursed by the schemes.

Masa says its concern is for patients who, unable to afford private health care any longer, will be driven into arms of the over-burdened state health-care system — a view supported by Namda. Masa is worried too by the power that will be vested in the hands of the medical schemes, which will have more leeway than they do now to decide what they will pay out for.

Namda says any revision of the health system should be negotiated by a forum of all concerned parties. Without such a forum, Namda wants a moratorium on all amendments to health legislation.

Masa, in its rejection of the proposed amendments, stated: "The political environment is of such a nature that it is no longer acceptable to make major changes without involving all

Health Minister Rina Venter

parties in a way which is considered by all to be democratic."

But some doctors believe this is all a red herring. It was an inappropriate issue for Namda to seize upon, they say, and a strategic error as Venter's attributes outweigh her negative points. These doctors point to the fact that Masa members who have always made use of the medical schemes have been treated "softly" by both the schemes and previous ministers of health.

But now that the system is under strain — the fault, at least in part, of the doctors themselves, for driving prices up — the schemes have successfully appealed to the minister for help. Therein lies the conflict.

The VAT issue over which Venter is also being called to task is another area in which the doctors' motives deserve closer scrutiny. Dispensing doctors have been particularly vociferous on this issue. Many closed their practices recently and took to the streets to voice their protest against the introduction of VAT on medical services and medicines.

Namda supported them. Masa was more muted on this issue, but moved to heal the growing rift between itself and the other groups by calling for Venter's resignation over the issue.

Some dispensing doctors have not been charging VAT and fear prosecution or punitive taxation if they are caught. Sources within the medical industry say many of the doctors who run cash practices are drawn from the ranks of dispensing doctors. Much of their cash never reaches the receiver of revenue and these doctors fear that the mechanisms set up to collect VAT will result either in prosecutions or a loss of income.

Many doctors do not feel that VAT on private health care is a problem, though most are opposed to taxing health care in state and provincial hospitals. "Health care is a commodity like any other," commented one.

Venter has also come under fire for not effectively implementing a primary health-care policy — a fact she obliquely acknowledges by stating that it is "in the national interest to proceed with the implementation of this plan in an orderly fashion".

The African National Congress and a need to remove Venter (and the entire NP government) from the health sphere, point to primary health care as a problem.

"Talking about primary health care is not enough," says ANC secretary of health Dr Ralph Mgijima. "A national health plan needs to be formulated by all concerned parties." This could be safeguarded by entrusting the task to a democratically-elected interim body from business, the unions, civic bodies and the medical profession, he says.

Both parties believe Venter has moved further on this issue than previous ministers, but does not have sufficient backing from the cabinet and her own department. They point to the fact that while inflation has been running at around 15 percent, the 1991/2 health budget was increased by just eight percent.

Venter has trod on powerful toes during her time in office. She moved swiftly and efficiently to ban the sale of skin lighteners, which had remained on South Africa's shelves long after the world had denounced them and local dermatologists had called for their removal. More controversially, she has mooted strong moves against smoking, thereby incurring the wrath of the tobacco industry — which also happens to own hospitals working in her domain.

Most noticeably, the minister of health is a woman and is not a doctor — which made her appointment an even more complete break with the past. But at least the general consensus is that this has played no role in the moves to remove her.

Medical costs: Call for debate

JOHANNESBURG. — There should be a reasonable debate to end the controversy over soaring health costs, the Pharmaceutical Manufacturers' Association said yesterday.

PMA executive director Mr John Toerien said in Pretoria that Dr Rina Venter, the Minister of National Health and Population Development, could not solely be held to blame for the current soaring costs of medical aid. — Sapa

FM 6/12/91

What's the prognosis for Venter?

Balancing competing interests is possibly one of the most difficult responsibilities of any Cabinet Minister.

This is particularly true for Health Minister Rina Venter. Of all the portfolios, health must rate as one of the most challenging in crisis-wracked SA. Aids, declining standards of health care — particularly at provincial hospitals — and escalating medical costs burden all. Even the relatively affluent white population is increasingly unable to afford essential treatment. Medical practitioners complain that patients refuse to take their proper dosages of medication because they can't afford the cost.

It is against this backdrop that her attempts to amend the Medical Schemes Act must be evaluated. If she succeeds, her efforts will go a long way towards deregulating the over-regulated medical schemes sector. An end to guaranteed payment and scales of benefits will certainly force health providers and patients to think twice about ordering every possible test for a migraine.

Opening up the industry to allow medical schemes to provide health services — run hospitals, employ doctors, pharmacists and other practitioners — will no doubt also serve as an incentive to health providers to be more efficient. Certainly, it will introduce competition.

Understandably, doctors are suspicious of the amendments. The proposals clearly threaten their absolute discretion in dispensing services. The Medical Association of SA (Masa) says the proposals give medical schemes unlimited monopolistic powers to control the use and provision of medical services. Masa also argues that risk-rating will discriminate against the poor, aged and sickly.

Certainly, Masa is correct when it accuses Venter of providing only an ad hoc solution to a national crisis but, given that money saved by the self-sufficient private sector can be reallocated to the needier sectors relatively quickly, Venter needs to be commended for her initiatives.

This, of course, doesn't mean she can rest. On the contrary, she must push ahead with reforms — particularly deregulation — even if this meets with votes of no confidence and calls for her resignation. Vested interests will always resist attempts to deregulate, even if these are in the long term advantageous.

Where Venter needs to be criticised is in her unwillingness to debate with interest groups in the press.

This is a remnant of Nationalist government, an era when Cabinet Ministers considered themselves accountable only to higher authority. ■

HEALTH-CARE INDUSTRY

Doctors don't like this prescription

The age-old battle between doctors — who provide the medical services — and medical schemes — who pay the bills — has degenerated to the point where practitioners are calling for the head of Health Minister Rina Venter, who supports deregulating the strictly controlled medical-schemes industry.

The Medical Association of SA, the National Medical and Dental Association and the SA Dispensing Practitioners have accused Venter of lacking leadership at a critical juncture for the health-care business. But most of all, they have attacked her support of proposed amendments to the Medical Schemes Act.

The legislation seeks to end guaranteed payments and scales of benefit. It also would scrap the maximum and minimum benefits for schemes. But most contentious is the amendment that would allow medical aid schemes to provide health-care services. In a nutshell, schemes would be able to run hospitals and pharmacies and employ doctors, nurses and other practitioners.

Needless to say, that does not go down well with dentists and doctors.

Medical Association chairman Bernard Mandell believes that the proposals would give medical schemes unlimited powers to control the use and provision of services. "The proposals are an ad hoc crisis-management attempt to address an escalating problem in only one particular area of health care. Our overriding concern is that the Bill does not address the strong and urgent need for efficiency and equity in the entire health-care system."

Rob Speedie, executive director of the Representative Association of Medical Schemes, favours the proposed deregulation because he believes it will cut the cost of health care dramatically.

He says the current fee-for-service system is more costly than a health maintenance scheme — which could be run by medical schemes — because doctors and patients trust that some "faceless" medical scheme will foot the bill. He blames overuse of health-care services, abuse by patients and health-care providers, and runaway costs of medicine and services for the current financial crisis in health care.

Medical schemes reportedly paid out R1,4bn more in benefits last year than the previous year, while the number of beneficiaries of schemes grew by only 1,9%. And the Department of Health said last week that 88 of SA's 200 registered schemes suffered operating losses last year — nine are said to be insolvent.

The Medical Association would like to make its own amendments to the Medical Schemes Act. In a detailed memorandum attacking the proposed legislation, it says the current scale of benefits is not a reasonable compensation for medical services.

Speedie, however, stresses that the scale is intended to provide affordable benefits to members, rather than reasonable compensation to doctors. "The scale of benefits is based on our rates. We don't print money, we can only spread it as far as reasonably possible."

Wits Commerce Dean Duncan Reekie, a medical economist, says the present system offers patients and doctors no incentive to cut costs. "One needs a system where doctors and patients know they will lose if they overprovide services."

Reekie suggests that a health maintenance programme can act as an incentive to doctors to be cost-efficient. He says doctors also will be wary of underproviding care. "Otherwise, patients will either keep coming back — which will increase costs and lower profits — or employers will take their business elsewhere. The incentive must therefore be not to overprovide or underprovide."

The association is not dead-set against the idea of managed health-care systems. Its memorandum supports such a concept, provided they are not operated for "financial exploitation" and they don't prevent or discourage medical practitioners from acting in the best interest of their patients.

Speedie retorts that doctors make money from their practices and he can't see why health-care programmes shouldn't be allowed to do the same. He nevertheless stresses that no medical scheme in SA operates for gain. "If medical schemes run health-care programmes, the profit motive could be eliminated. Of course this poses a threat to vested interests, but costs of care would be reduced.

"Our concern is not with doctors' earnings — if they work hard, they are entitled to make money." The problem, he says, is that there is now no incentive to eliminate waste and abuse. There's also little competition. In this regard, the Bill makes massive strides.

While the association admits that there are advantages to be gained from the legislative proposals — improved financial positions for schemes, tailoring packages to meet individual preferences, competition between medical schemes and insurance companies leading to innovation and improved efficiency, and incentives to discourage overuse of services — it says the disadvantages are greater. "The increased use of risk-rating will result in a strong shift towards designing packages for healthier, younger people. The old, poor and more sickly will be discriminated against and responsibility for the indigent will shift on to the State."

Speedie disagrees. He says the increased use of risk-rating will lead to greater efficiency and less abuse. "Only people who misuse and abuse the system will be penalised. To say that sick people will be penalised is not true. Cross-subsidisation will continue to apply as it does in every insurance system." He says the burden of the indigent has always been carried by the State. "They have never belonged to schemes."

Considering the tentative way in which government moves toward deregulation, it doesn't seem possible that Venter is moving too fast or too far. If the goal of medicine is to get it to as many people as possible in the least expensive way possible, then the only answer can be to give the practitioners some competition. ■

MEAT DEREGULATION

Where's the beef?

Just two months ago government seemed ready to free the tightly controlled meat industry. With consumers angry at soaring prices, and producers lost in a maze of restrictions, deregulation was in the wind.

"The industry has now matured sufficiently to allow for freer competition and the increased availability of meat supplies at all markets," said Agriculture Deputy Director-General Chris Blignaut (*Business & Technology* October 25).

But the wind has now turned against deregulation. Government is apparently capitulating to bureaucrats, wholesalers, abattoirs and other vested interests in the R7bn-a-year meat trade. The Committee of Enquiry into the Deregulation of the Meat Industry was appointed by government five years ago and

'Vision needed in medical services'

Sowetan 6/12/91 (85)

Access vital to health system

By MOKGADI PELA

OVER the past 15 years a number of authorities have lamented the inadequacy of occupational health services in the country.

Yet the solution is plain - worker access to a comprehensive health system.

This is supported by two recent South African articles that have proposed models for occupational health services.

Myers and Macun look at the organisation of services on a national level.

Throughout the world attempts are being made to improve equity and efficiency in health care by providing comprehensive care through primary care teams in community health centres that are close to work or home.

To be most effective, however, primary care needs support from, specialist services. In common with other special areas of health care, such as mental health, child health or rehabilitation, occupational health is at present cut off from general health care, rendering the service fragmented and inefficient.

An article in the latest issue of the *South African Medical Journal* says comprehensive care requires that prevention be linked to cure. Occupational health and safety emphasises prevention of work-related injury and disease by improving the working environment.

But workers - like everyone else - want easy access to a service that offers relief symptoms. They want a cure. Preventive services, aimed at avoiding risks of events in the distant future, are unlikely to win popular support and co-orperation if injuries and disease are not diagnosed and treated.

Curative services have the further advantage of repeated contact with individuals, allowing ongoing surveillance, and early detection of occupational disease.

Detecting disease, whether through screening examinations or individual consultation, helps target preventive action. Preventive measures, such as industrial hygiene, can have a substantial impact on public health, but this can only be realised with sufficient resources.

This continual welding of preventive and curative functions requires special skills. Despite growing public awareness of work-related diseases, most doctors usually fail to take an appropriate occupational history, lack a rational diagnostic approach, and are unfamiliar with criteria and procedures involved in compensation claims.

Providers of primary care need to consider work-related causes in relation to many diagnoses, especially concerning malignant disease and illnesses of the respiratory, dermatological and nervous systems.

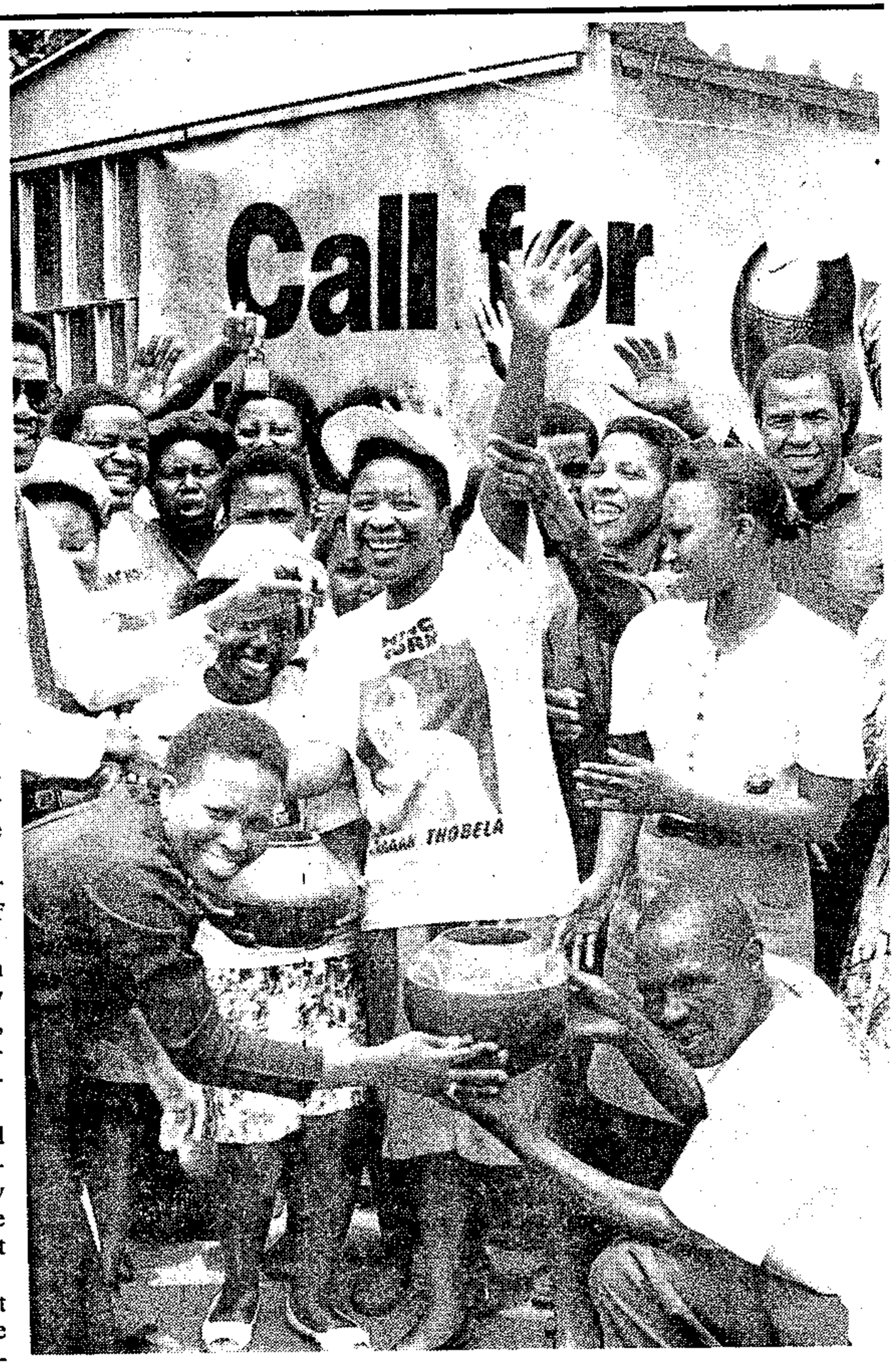
Occupational health practice requires particular abilities, such as history taking - with a knowledge of typical hazardous exposures in each occupation.

Health worker training programmes in South Africa need more emphasis on work-related disease. Primary care professionals, whether family doctors or nurses, need to be aware of how their patients' health is influenced by the social, physical and occupational environment.

In addition, there is a need for more and improved training of occupational health physicians, workers, factory inspectors and industrial hygienists.The goals may best be implemented in training institutes that have close links with occupational health services, so that learning is based on practical experience.

The SAMJ argues that these demands are not Utopian. If health services are to be extended to those who need them most, with a greater emphasis on prevention, then occupational health should be accommodated.

The suggested changes are feasible and affordable. But in this field South Africa needs vision and determination.



Mrs Thembi Khumalo of Orlando West receives the key of the door from Mr Colin Nxumalo for the new King Korn hut she won. Mrs Khumalo, who was surrounded by friends and well-wishers at the presentation, also won hundreds of rands worth of groceries with which to start her own business. There were nine other winners in the contest.

Venter invites Masa to talk

The Medical Association of South Africa has been invited to hold quarterly discussions with the Minister of National Health and of Health Services and Welfare, Dr Rina Venter, in an attempt to satisfy its demand to take part in the policy-making process, Dr Venter said yesterday. STAR 12/12/91

Her statement came after a meeting between herself and Masa to discuss their problems. Masa recently called for the minister to resign.

Dr Venter said she also regarded liaison between her department and the medical profession, through the Professional Forum, as important.

During the discussion, Dr Venter told the Masa representatives that she had been given the task of restructuring health services and ensuring it was brought within the financial means of the State. (85)

A balance would have to be achieved between a sophisticated medical model and a broad health approach, she said.

The strongest possible correlation would have to be found between the health approach and the general health status of the population and the restructuring programme that the minister was currently implementing.

Dr Venter welcomed Masa's request to take part. — Staff Reporter.

New Bill to provide 'cheaper' health

CAPE TOWN — Health Maintenance Organisations (HMOs), which are to be encouraged in terms of proposed legislation, will provide a much cheaper form of health care service than medical aid schemes, says Quentin Robinson, director of Medicaid, one of only two schemes operating a form of HMO in the country.

Robinson said years of unchecked abuse by medical practitioners and patients had seen a dramatic leap in the cost of some medical aid membership fees, with some schemes charging monthly subscriptions of between R600 and R1 000.

Own Correspondent

He said Medicaid had proved that the cost of medical services and medicine could be slashed by half by operating HMOs.

Although there was no choice in which doctor a member could visit or what medicines were dispensed, the concept had kept costs down.

The HMO concept has prompted Health Minister Rina Venter to introduce a draft Medical Schemes Act which seeks to provide affordable health care for 11-million people.

The Bill, which has been rejected by the Medical Association of SA (Masa), will allow medical aid schemes to contract only with doctors or medical services prepared to operate within affordable rates.

Robinson said doctors contracted by the scheme would receive incentives if they kept consultations down and dispensed medicines only when necessary.

He said this week's "hoo-haa" by Masa over the draft act promoting the scheme was the result of the "vested interests" of many doctors.

Public 'blind' to crisis in health top medic

SOUTH AFRICANS do not appear to be aware of the crisis in medical services, the president of the College of Medicine of South Africa, Professor John Terblanche, claims.

He was responding to a programme on the crisis compiled by Mrs Elna Boesak and broadcast by the SABC on Good Morning South Africa on Thursday.

Professor Terblanche said the college had pointed out that medical services had been on the decline "as far back as September 1988".

'Underfunding and understaffing has now reached the critical point where several teaching complexes face imminent collapse.

"The academic institutions cannot continue to run effectively in a situation where they are facing increasing numbers of patients and an ever-decreasing budget.

"It would take generations to repair the damage."

If academic institutions collapsed, public and private medical care would be dealt a mortal blow, Professor Terblanche said. "We need action immediately."

Masa submits grievances to Venter

The Medical Association of South Africa (Masa) this week submitted their grievances regarding health policy to Health Minister Dr Rina Venter. Masa chairman Dr Bernard Mandell said the discussions were frank and focused on grievances regarding the management of health care and the formation of health policy.

SURVIVAL

ARG 20/12/91 (85)

'Women survive better than men'

From NANCY COSTELLO for Sapa-AP in Seattle

WOMEN are twice as likely as men to survive extreme cold and hunger, based on new research of the Donner Party, 19th-century pioneers who resorted to cannibalism to survive winter in the Sierra Nevada.

More body fat, a lower metabolic rate and a temperament that is less prone to aggression make females the hardier sex when it comes to surviving disaster, said archaeologist Mr Donald Grayson of the University of Washington.

In analysing death patterns of the Donner Party, Mr Grayson found females who were older than five, but younger than 50, and part of large families had the highest survival rate. Of the group's 53 males, 30 died, while only 10 of the 34 females died. Only 47 survived.

"I found it especially interesting that so many men died so early," he said. "They just went like flies."

The group was marooned in the mountains for six months, from October to April.

Of the 25 men who died after reaching the Sierra Nevada, 14 died by the end of January, while all of the 10 females who perished died in the later months.

Results of Grayson's study were published in the *Journal of Anthropological Research*.

Eighty-seven pioneers, led by George and Jacob Donner left Springfield, Illinois, by wagon train in August 1846 bound for California's Sacramento Valley.

The group was delayed travelling an untested route between Wyoming and Nevada, and found itself starting over the mountains in eastern California just as the winter snows hit.

Camped out in log cabins for the winter, the pioneers ate their draft animals, pets and a "soup" made from boiling animal hides and bones.

"We had to kill litte *Cash* the dog and eat him — we ate his entrails and feet and hide and every thing about him," wrote Virginia Reed, a 12-year-old survivor.

By February, Donner Party diaries show that to stay alive pioneers were eating their dead and the practice had almost become routine.

"Mrs Murphy said here yesterday that she thought she would commence on Milt and eat him ... it is distressing ..." wrote Patrick Breen, a 40-year-old survivor.

The demographics of the Donner Party provides a solid case of "natural selection in action," said Mr Grayson.

The pioneers struggled with both extreme hunger and intense cold.

Age, the size of one's social group — and most of all, sex, — the archaeologist said, were key in determining who lived and died in the 3-meter snows of the Sierra Nevada.

Women have a greater percentage of surface fat that insulates them against cold, said Mr Grayson.

Females also consume energy less quickly than men — an adaptation that aids pregnancy — thereby holding an extra store of energy.

Such assets may have helped women survive an attempt by 13 pioneers to snowshoe out of the mountains in late December. Five women and eight men made the 33-day trip. Six died — all men.

Focus on private health

THE National Health Services and Welfare Department yesterday announced a forum on private health facilities to be held in Pretoria on January 27 and 28.

National Health Services and Welfare Minister Rina Venter said aspects to be discussed included the body or bodies responsible for the granting of licences and the way in which applications ought to be considered and criteria for the construction and management of private facilities.

FM 20/12/91.

Dr Venter's prescription

Deregulation of the medical closed shop would begin to meet the challenge

Judging by recent calls for Health Minister Rina Venter to resign, you'd think she was an intern who had left a scalpel in a patient's stomach. Objections to her have come from what looks on the face of it to be a powerful lobby — people such as the Medical Association of SA (Masa), the National Medical & Dental Association, the SA Dispensing Practitioners, and others.

Venter is accused of lacking leadership and failing to deal with admittedly critical problems facing health care — in particular, spiralling costs. Health-care services in the public sector continue to deteriorate fast in the face of increasing demand by a growing number of impoverished — but also increasingly politically empowered — claimants.

In the private sector, almost half of the medical aid schemes report operating losses totalling around R100m for 1990 as they battle to contain claim costs within the limits of subscription revenue. Medical scheme expenditure on benefits rose by an alarming 36% over 1989, which resulted in subscriptions for 1991 being increased by over 25%. Many members are reviewing or even surrendering their policies.

Venter's critics come mainly from this sector — within the commercial health-care delivery system — and their accusations smack of self-interest. Certainly, she hasn't presented a cure-all grand national plan to redress the gross imbalances of the public health service, an apartheid legacy, but she has made certain proposals which, if implemented, will go a long way towards deregulating health care and introducing competition in a sector that over the years has embraced a closed-shop mentality.

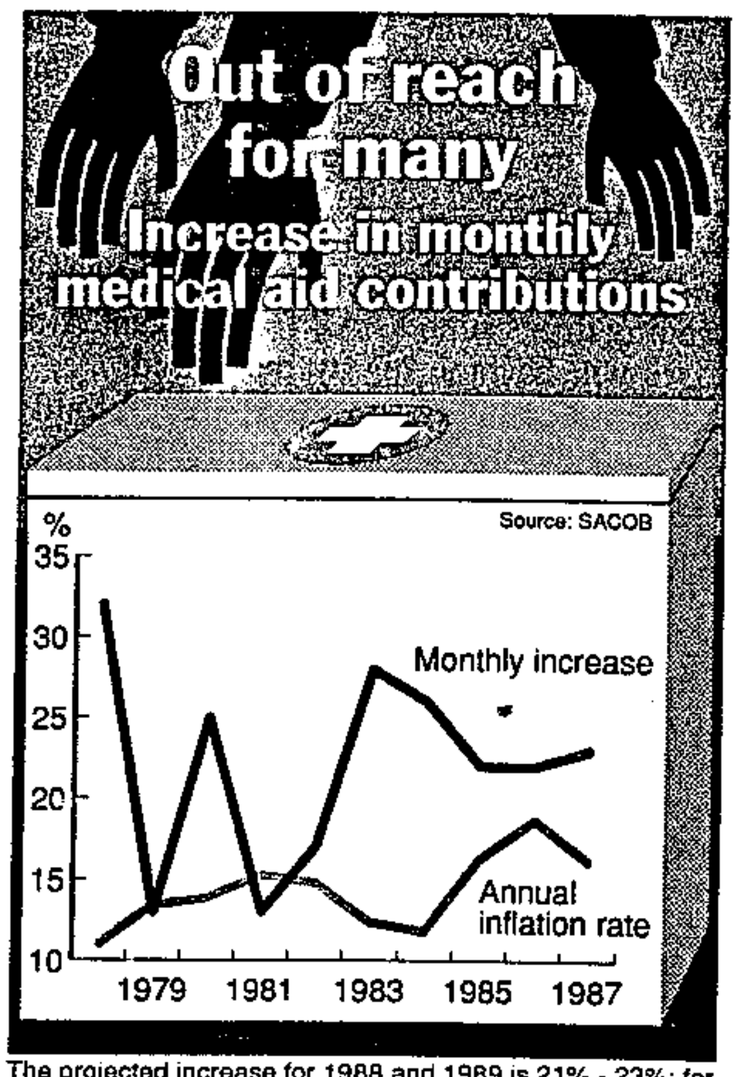
Critics have found particularly objectionable her support of amendments to the Medical Schemes Act to end statutory guaranteed payments and scales of benefits, which are said to encourage the overuse of health-care services. Her most far-reaching and controversial innovation, however, is an amendment that would allow medical schemes to provide health-care services themselves — that is, run hospitals and employ doctors, nurses and other practitioners at fixed salaries to cater for members' needs.

Doctors see this as a threat to their absolute discretion in dispensing services, and are concerned that medical schemes could acquire unlimited powers to control the use and provision of services. Says Masa health policy director Reg Magennis: "The involvement of medical schemes in the employment of medical practitioners holds the danger that the requirement placed on schemes to minimise costs could translate into an improper pressure on professionals to conform to the cost-saving dictates of lay people."

So doctors see in Venter's proposals a dilution of their professionalism. Magennis warns that the involvement of medical schemes in employing practitioners will partially destroy the scope for the financial cross-subsidisation practised by some doctors serving both affluent and poorer communities. The poor will be thrown back into the inadequate State sector, increasing the ultimate burden on the taxpayer.

But Venter and supporters of the amendments say that health maintenance schemes run by medical schemes have proved cheaper than the current fee-for-service system that offers no incentives to doctors — or patients — to be cost-effective.

Rob Speedie, executive director of the Representative Association of Medical



The projected increase for 1988 and 1989 is 21% - 23%; for 1990 it may be more than 25%

Venter

continue —> P.T.O.

Thsepiso, an area between Sharpeville and Boipatong.

Madise said the agreement was signed at a news briefing on Tuesday. "The agreement stipulates that the community should not be left out of the project ... it should be involved." He could not give the size of the project nor the date on which it would start.

"Next February will see the 40 niversary of my father's death a my accession.

"Over the years I have tri follow my father's example a serve you the best I can. You given me in return your loyalt

US study finds SA's health policies lacking

Bday 27/12/91 (3) (85)

DAVE LOURENS

SA COMBINES the worst health consequences of industrialisation and poverty — a high incidence of heart disease among whites and widespread preventable diseases among blacks, a new US study has found.

Economic progress, it says, needs to be coupled with effective financing and management if the health status of SA's people is to improve.

The study, conducted by the SA Medical Research Council in conjunction with the Washington-based Kaiser Family Foundation, found that health policy was shaped mainly by political considerations rather than national health priorities.

Although an effective national primary health care system could significantly improve the population's health status relatively quickly, a 10% annual economic growth rate would be needed to eliminate poverty within the next decade.

SA currently spent 5,8% of its GNP on health care, compared to the World Health Organisation's (WHO) minimum standard of 5%. A disproportionate amount of this expenditure went to white health care.

SA had enough hospital beds to serve the entire population, but urban areas had a surplus while rural areas were neglected. There was a surplus of 11 700 beds for whites but a shortfall of 7 000 for blacks.

The WHO recommended an ideal bed/population ratio of 1:200. In SA there was one bed for every 150 whites, but only one bed for every 260 blacks.

To resolve these disparities, the bureaucracy of health administration needed to be disentangled, and access to health care needed to be rationalised, with particular emphasis on removing discrepancies between rural and urban facilities.

While the need for substantial reform in the national health system was accepted by government and non-government health sectors, its nature was disputed.

The study said the state believed those who could afford to pay for care should do so, freeing more funds to subsidise state patients. The non-government sector, including liberation movements and left-wing medical groups, believed fees for service care promoted unequal care, and the existence of a private sector undermined the public sector by offering higher salaries and better working conditions.