



## HEALTH HORROR IN PACKED POLLSMOOR



SAMA's Human Rights, Law and Ethics Committee has been chastised by new SAMA chairperson, Dr Kgosi Letlape, for 'gross dereliction of duty' in allegedly not tackling reports of dismal health conditions at Pollsmoor Prison.

Letlape was responding to a claim by Pollsmoor contract doctor, Dr Steven Craven, that complaints to the SAMA committee had done little to challenge bureaucratic bungling, buck-passing and inaction by national and provincial government.

Craven presented a litany of government bungs in response to his documented evidence of unsanitary conditions. He described Pollsmoor as a 'medical disaster' in which 4 300 prisoners were living in 'indescribable squalor and filth'.

Addressing SAMA's annual National Council meeting in mid-September, Craven said he had reported the situation to the Human Rights, Law and Ethics Committee after Inspecting Judge Fagan told him the situation was 'even worse at upcountry prisons'.

'The way SAMA is looking after the needs of South African prison patients is a disgrace,' Craven said. Letlape responded that much depended on SAMA board members and sub-committees doing their jobs properly.

Dr Thabo Rangaka, chairperson of the new Physicians for Human Rights NGO,

said Craven's unresolved complaint 'illustrates something from the past - that SAMA does not tackle these issues head-on'.

Rangaka promised that he would press prison doctors for all relevant information before joining forces with SAMA's Ethics Committee and the SA Medical and Dental Council to 'tackle this from an NGO perspective'.

Letlape invited Rangaka to join SAMA's Ethics Committee, but he declined, saying his group was 'about doing, not talking'.

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***'SAMA has done little to challenge the bureaucratic bungling, buck-passing and inaction by government.'***

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Craven told Council that 90% of Pollsmoor communal toilets were not working, that prisoners were not sent to hospital at appointed times, and that they did not receive the medication he prescribed.

This year a Ghanaian prisoner had died of fever and two prisoners had died of untreated pulmonary TB, while he had treated three warders for pulmonary TB.

Cells held three to four times the number of people for which they were

designed. Conditions were so 'squalid and unsanitary' that multi-drug resistant TB, Shigella and Salmonella infections were rife.

Craven said he dreaded the appearance of cholera and the traditional jail fevers of typhus and typhoid.

On 2 October, three weeks after SAMA's Council, Craven told the National Assembly's Correctional Services Committee that there had been an outbreak of dysentery at Pollsmoor. The maximum security section, designed for 1 619 inmates, now housed between 3 500 and 4 000 prisoners.

He told the Committee that the ratio of health care providers was supposed to be one nurse or orderly for every 200 prisoners, but was in fact one per every 1 000 prisoners.

Prisoners were not required to wash or cut their hair, resulting in 'endless' problems with fleas, lice and scabies.

Craven said that in August this year, following an outbreak of Shigella and Salmonella, he reported the gross deficiencies in cleaning, hygiene and sanitation to the 'relevant health inspector' - who was promptly refused access by the prison governor.

He said inmates were not kept constructively occupied so they resorted to 'smoking dagga and causing trouble'.

Mr Frans Muller, Pollsmoor's Assistant Director of Nursing Services, told the SAMJ that nearly all of the problems outlined by Dr Craven were a direct result of overcrowding.

Although many gangsters had low hygiene standards, there were simply too few showers to cope with the demand, so many prisoners had to go without washing. Toilets were also no sooner repaired than they were vandalised again.

Muller said he hoped that the current R55 million electrical and plumbing upgrade of the prison, would make some difference.



# CLEARLY

He reported that he was operating on one sixth, not one fifth, of his health care staff requirements. He estimated the health care worker to prisoner ratio was actually 1: 300, compared with the statutory requirement of 1:50.

'It's a big problem - we recently advertised posts but everything takes so long and in the meantime we must cope with this hell of a workload'.

Muller told the SAMJ that the maximum security hospital section had 45 beds, all of which were 'nearly always occupied'.

He said the movement of prisoners, granting of bail and their constant deliberate changing of names, made compliance with drug regimens often impossible.

As for patients not being brought for treatment, he said the warders often 'just target' to bring them down.

'We are at the receiving end of the criminal justice system here and try and correct things where all the other people fail. But the numbers just keep increasing,' he said.

He said that in the Medium A (juveniles) and Maximum Security sections, 70% of prisoners were awaiting trial.

Muller agreed that most were not kept constructively busy but said they were given an opportunity to exercise once a day in the courtyard.

His comments were echoed by a 'shocked' Provincial Health MEC, Nick Koornhof, after a tour of Pollsmoor's Maximum Security section on 5 October.

Describing the situation as 'a scandal', Koornhof said he encountered 53 awaiting trial prisoners in a 50 square metre cell and that the section, built for 1 619 prisoners, housed 3 250.

Koornhof said he doubted the R55 million upgrade would address the current problems and called for Correctional Services to employ more nurses and their own doctors. He promised to approach the Health Minister urgently.

The outgoing head of SAMA's Ethics committee, Dr Fazel Randera, said that

upon hearing Craven's initial complaints, his committee had resolved to reiterate SAMA's position on the care of prisoners, obtain documentation on the prison conditions, and request an urgent meeting with the Minister of Correctional Services, Ben Skosana. Another priority was establishing whether the situation was pervasive in the prison services.

The committee had scheduled a meeting with the Prisons Inspecting Judge Fagan, and 'hopefully' the Commissioner of Correctional Services, for 17 November.

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***'Pollsmoor is a medical disaster in which 4 300 prisoners live in indescribable squalor and filth.'***

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Randera added that 'it's a sad reality that there's always a gap between the Constitution and the practice'.

He said prison health had been 'high on our agenda ever since MASA transformed into SAMA'.

Randera emphasised that his former committee's main task was to develop ethical and human rights guidelines. SAMA's Board would have to decide 'whether that means we become activists and go to prisons and verify and justify what's going on in any given situation'.

The Board would also have to take into account that there were a number of structures in South African society which could deal with the issue.

Randera saw the way forward for the Ethics committee as following up on the documented evidence and 'if necessary, meeting with the Human Rights

Commission and knocking on the door of the Minister'.

Mr Braam Volschenk, head of SAMA's legal unit, said he had a file full of meetings with role players and letters written to Correctional Services, the Public Protector, Lawyers for Human Rights and inspecting judges.

He and Dr Len Anstey, chairperson of the Cape Western branch peer review committee, had visited Pollsmoor twice.

'I think there's not much commitment from prison authorities to really improve health care,' Volschenk said.

The new chairperson of the Human Rights, Ethics and Law Committee, Dr Anand Chetty, has invited Craven to the 17 November meeting of the committee in Pretoria.

Craven said the only reason Pollsmoor was gaining public attention was that it was near a SAMA branch and had the 'misfortune' to have him as the doctor servicing its maximum security section.

He had meanwhile received nothing but encouragement from prisoners, colleagues, private patients and Judge Fagan since his testimony to the Parliamentary committee appeared in *The Cape Times* of 3 October.

He was however understandably less popular with the Pollsmoor Prison governors.

**Chris Bateman**





## FROM A PRISON DOCTOR'S CASE BOOK...

**27 Nov 1997:** Prisoner depressed - ordered NOT for single cell. **16 Feb 2000:** Found dead, hanging in single cell.

**8 Jan 2001:** Prisoner seen with 4 cm cellulitis on forearm. Ordered erythromycin, NOT issued. Re-paraded **10 Jan 2001** with 15 cm cellulitis and much pus - had to be sent to hospital.

**19 Jan 2001** NOT paraded. **8 Feb 2001** paraded with new folder. **21 Feb 2001** not paraded. Sent to theatre.

**12 May 2000:** Case of pulmonary tuberculosis. NOT notified, NOT treated and NOT received double rations. Discovered on **27 Oct 2000** when next paraded with weight loss. **31 Jan 2001** AAFB reported, tabled

**7 Feb 2001** on which day there was NO record in the folder of any TB treatment having been given. **26 Feb 2001** NOT paraded; FBC reported, tabled **5 Mar 2001**. **28 Feb 2001** AAFB culture +ve reported, tabled **5 Mar 2001**. **22 Mar 2001** AAFB reported, tabled **23 Mar 2001**. **9 Apr 2001** NOT paraded - warden refused to bring him from the Section. **12 Apr 2001** AAFB x 2 sent, reported **18 Apr 2001** and tabled **24 Apr 2001** on which day still NOT paraded. **18 Apr 2001** NOT weighed and NO Hb. **18 and 23 Apr 2001** changed TB treatment - NOT effected. **23 Apr 2001** sputum NOT sent to lab. **1 May 2001** eventually paraded. **24 Apr 2001** AAFB sens. reported, tabled **3 May 2001**. **1-8 May 2001** et seq. NO TB treatment recorded

on blue card. **13 Sep 2001** HIV +ve reported, tabled **25 Sep 2001**. **19 Sep 2001** AAFB direct x 2 reported, tabled **25 Sep 2001**.

**End April 2001:** Prisoner fell off top bunk and broke femur. Comes to the nurse's attention **24 May 2001**. Consensus of opinion of the Victoria Hospital's orthopaedic surgeons is that the fracture was about 1 month old.

**25 June 2001:** Ten nurses and orderlies not on duty in hospital section. (Doctor visits from 7.15am until about 1pm). Illustrates high absenteeism as a result of poor morale and bad conditions.

Dr Steven Craven

## SAMA-ONLINE NEWS <http://www.samedical.org>

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## GUARDING THE CITADELS OF AIDS STATS

The government has been aware of the findings of the Medical Research Council mortality report for 11 months.

The controversy peaked in the press last month when the Department of Health refused to release the MRC findings, saying the report first had to go to Cabinet and could only be seen by the public at the end of the year.

The SAMJ has also learnt that the government is planning a R100 million media AIDS awareness campaign from December to counter the barrage of negative publicity surrounding its response to the epidemic.

Minister Tshabalala-Msimang has called provincial health ministers together to co-ordinate and plan a major awareness drive on mother-to-child transmissions, sexually transmitted diseases, voluntary counselling and the targeting of schools.

Among the MRC findings leaked to the mainstream media and corroborated by SAMJ sources, are that 40% of the deaths of people aged 15 to 49, and 20% of all deaths last year, were due to AIDS.

The report is authored by the MRC's Burden of Disease Unit chief, Dr Debbie Bradshaw, and her colleague Ria Loubser of their Biostatistics Unit, UCT's Professor Rob Dorrington (Centre for Actuarial Research) and David Bourne (Public Health), and Dr Ian Timaeus of the London School of Tropical Medicine and Hygiene's Centre for Population Studies.

The report estimates that the disease will kill more than six million by 2010 and states categorically that more South Africans die of AIDS-related illnesses than from any other cause.

The final report came from the MRC printers on 20 September and was handed to the Minister of Health's office 'within days,' according to the SAMJ source.

However, the MRC source was emphatic that these major findings are identical to those sent to the Minister and other key decision makers 11

months ago in an urgent 'advisory note,' aimed at flagging the public health threat.

Dr Tshabalala-Msimang's office confirmed to the SAMJ that it received the note entitled, 'Briefing on Increase in Death Rates,' in November 2000, but claimed it 'only contained assumptions' about the impact of HIV/AIDS.

Ministry spokesperson, Mr Sibani Mngadi, said the note stated that there had been an increase in reported deaths and that 'one of the reasons' was the increase in the coverage of death registration from about 50% in 1990, to over 90% in 1999. He said the note had urged government to 'continue with its efforts' to reduce the impact of HIV/AIDS.

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**Archbishop Ndungane:  
'Withholding of report  
suggests chicanery behind  
the scenes which could lead  
to disaster.'**

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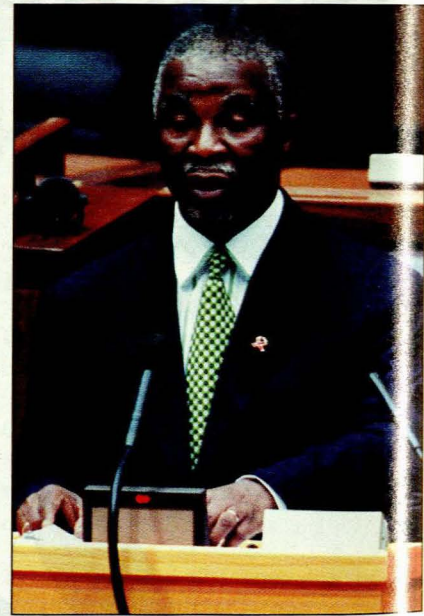
Mngadi confirmed that in her acknowledgement of the note, the Minister said she 'looked forward to receiving copies of the technical reports once they are finalised'. He said she had viewed the note as 'an information sharing exercise on a work in progress'.

An angry top MRC source said all respectable research models contained assumptions and dismissed the official comment as 'spin-doctoring'.

The government heel-dragging on the MRC report came amid the leaking of an explosive letter from President Thabo Mbeki to Tshabalala-Msimang dated 6 August.

In this he reportedly asked her to review health spending in the light of 1995 WHO-AIDS data which put AIDS-related illnesses at just a fraction of the latest data.

The seeming reluctance to release the MRC report and the Mbeki letter



boosted the broadening civil alliance determined to confront the government head-on about its AIDS policies.

The government's increasingly outspoken political partner, COSATU, the Anglican and Catholic Churches and the Treatment Action Campaign (TAC) last month joined forces to challenge the 'state of denial'.

At a press conference held at Bishopscourt in Cape Town last month the group said the government must 'wake up' from its denial over the number of people infected and dying from the disease.

They called for the declaration of a State of Emergency, a boosted health budget, the provision of antiretroviral and other treatments and the expansion of awareness campaigns.

The TAC has filed papers in the Pretoria High Court aimed at forcing the government to provide Nevirapine to pregnant mothers to prevent infant infection on a wider scale than the existing 18 pilot projects.

AIDS Director Dr Nono Simelela, told the SAMJ that there were now in fact 153 state health care facilities country-wide offering ART to prevent mother-to-child transmission.



Speaking on behalf of the new alliance, Anglican Archbishop Njongonkulu Ndungane called for the release of the MRC report, 'so we can judge for ourselves'. He added that 'we are not children, we are adults'.

He said the withholding of the MRC report suggested 'chicanery behind the scenes which could lead to disaster'.

Dr Simelela told the SAMJ that there

was not a shred of doubt in her mind that AIDS-related deaths had increased and that there was now 'enough data to plan on'.

'However we can get much more sophisticated in our collection of data. For example, it's clear that more specificity is needed with death certificates around the defining diseases of AIDS. We know that TB's a problem,

but we need to look at other infections so we can focus on prophylaxis. What else are people dying from besides TB? We need to identify, define and treat early and aggressively,' she said.

Her observations drew enthusiastic nods of agreement from MRC researchers.

Chris Bateman

## CHRONOLOGY OF A CLAMPDOWN

*A chronology of the MRC's sharing of its AIDS mortality findings and the official responses, as could best be reconstructed by the SAMJ.*

**November 2000:** Summary of major findings 'note' sent to Minister of Health and other key decision makers.

**December 2000:** Minister acknowledges receipt of letter.

**April 2001:** Debbie Bradshaw, director of the MRC's Unit for Burden of Disease, sends her draft technical report to the Department of Health and Statistics SA, requesting comments. No response from the Department of Health.

**A week later:** Dr Suleiman Bah, senior demographer at Stats SA responds, congratulating Bradshaw on the 'valuable work' and saying Stats SA needed 'several perspectives and rays' on it to cast light. Bah emphasises that they're approaching AIDS data from a 'theoretical angle'.

**June 2001:** Dr Tshabalala-Msimang asks the MRC to prepare a Cabinet memo focusing on mortality trends and the impact of HIV. Request fulfilled (seven pages with major findings repeated). No feedback and Department of Health tells MRC that it wants to 'discuss' the report.

**August 2001:** Bradshaw updates Bah, who acknowledges the importance of the

data, especially being based on Department of Home Affairs population figures.

Department of Health sets up a task team of Home Affairs, Social Welfare and the MRC to discuss the issue of loose terms of reference.

**3 September 2001:** Bradshaw and her group present their report to the Department and Stats SA, emphasising their collaboration with top epidemiologists, medical statisticians and demographers. All present agree that the science is robust.

**5 September 2001:** Department requests another MRC presentation by Bradshaw and Dr Lindi Makubalo, a Department chief director, to 'social cluster' group of Director Generals.

**10 September 2001:** Mbeki's 6 August letter leaked to *Business Day*.

**16 September 2001:** *Sunday Times* publish leaked draft versions of the MRC technical report. Controversy erupts.

Several alarmed provincial health ministers ask MRC for final report. MRC refuses and its chief, Professor William Makgoba, orders all final copies locked up and consults his Board.

The three government ministers in charge of AIDS policy release a joint statement referring to MRC staff as

'government employees'.

**18 September 2001:** MRC releases the following statement:

'We recognise that the findings are of major public interest with enormous and serious policy and public implications for our country in the future.

Given the significance of the findings, the MRC decided to pursue the process of informing the policy-makers of our country through several briefing and discussion processes. These processes are currently underway during which the MRC has received useful and constructive feedback from the other government agencies who are using different methodologies and approaches to analyse the same problem. When these processes are completed, the MRC will release the report. We have every confidence that our country's policy-makers will expedite this process in the interest of informing the public.'

Debate rages over MRC autonomy from government - 65% of funding comes from the state. MRC Board agrees that release of findings should be delayed so that 'all stakeholders and policy makers' can be consulted first.

**5 October 2001:** *Mail and Guardian* publishes the full MRC report findings, leaked from among 100 final copies provided by the MRC to government.



## MFENYANA'S NEW MODEL FOR RURAL MEDICINE

A model of rural medicine linking clinics to academic centres is thriving in the Eastern Cape and has been integrated into the Department of Health's network.

Funded by the Kellogg Foundation and run by Professor Khaya Mfenyana, head of Family Medicine at Unitra, the project has four rural health centres in and around Umtata.

It closely parallels Kellogg-funded work being done at Wits University (Hillbrow) and the University of the Free State (Manguang township).

Mfenyana said the Ngangelizwe township clinic in Umtata had ten nurses and two doctors seeing up to 15 000 patients per month - a massive increase from 2 000 patients per month when it first opened in 1997.

A second clinic is situated in Mhlakulo towards Durban, a third at Baziya, 48 kilometres from Umtata

towards Queenstown, and the fourth is situated at Mbekweni, 18 kilometres out on the East London road.

Mfenyana said the system had enabled the closure of the outpatients department at Umtata Hospital. Now the clinics are integrated into the referral chain and the Department of Health funds posts.

Mfenyana, who began as a private practitioner in Cala in the early 1980s, moved to lecturing family medicine at Medunsa before taking up his current post in 1989. He also spent two years at Michigan State University doing a Masters in Educational Administration.

This background led him to found the Unitra Community Health Partnership Project. In this, all the clinics linked to Unitra have 24 hour service and maternity sections. Community service doctors rotate through them.



Mfenyana was recently made Honorary President of SAMA's Rural Doctors Association (Rudasa) in recognition of his 'pioneering work in educating doctors for rural practice'.

It is the first time Rudasa has created such a post, which has a three-year tenure.

Mfenyana said he was certain other deserved the honour more but 'promised to give Rudasa 'advice and support and meet with the powers that be to contribute to rural medicine'.

Chris Bateman

## SALARY NEGOTIATIONS TURNAROUND

The belated signing by public sector unions of the government's salary offer of a 6.5% to 8% increase from 1 July 2001, warded off a potential crisis as it halted the employer's unilateral implementation of a 5% increase.

SAMA was very concerned about this stance taken by government following

certain unions' refusal to sign the agreement by the deadline of midnight on 10 October.

Professor Denise White, chairperson of SAMA's Fulltime Practice Committee, said a 5% increase would have been unacceptable, and could have led to serious repercussions such as the further erosion of morale and more skilled people leaving the public service and the country.

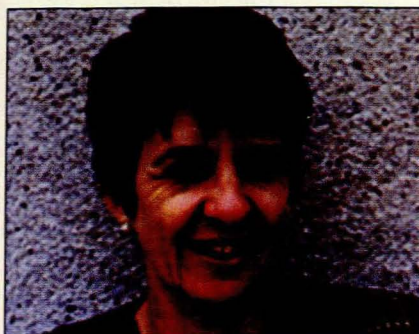
'Unfortunately there is more to lose than gain on all sides in such stand-offs between labour and government', she said. She felt strongly that punitive measures which hurt people financially can only result in a deeper divide between state and employee. 'Doctors in the public sector are small fry tagged on to large union bodies with little if any clout in influencing negotiations'.

Professor White emphasised that SAMA has sympathy for the real concerns and grievances of unions, but said the specific issues affecting doctors' conditions of service such as appropriate remuneration packages and career pathing were not receiving attention as they were lost in the mainstream of the collective bargaining process.

She said it was essential that doctors be included in the proposed category of 'scarce skills' which government has agreed must be identified for specific attention in order to retain expertise in the public sector.

'In the meantime, we are relieved that reason has prevailed and that the current negotiation between labour and government has been satisfactorily resolved,' she said.

Magda Naudé



Professor Denise White



## JUDASA INTERN PERSISTENCE PAYS OFF

SAMA's Junior Doctors Association (Judasa) is thrilled with the results of the intern post allocation process for 2002.

At a ratification meeting with the Department of Health on 17 September, it was confirmed that nearly every student received their first choice in the first round of the allocation process.

Prior to this meeting, Judasa was extremely unhappy about the perceived lack of commitment by the Department to accommodate students' first choices as agreed to previously, and even contemplated legal steps.

Following on discussions between SAMA and the Department, every single mistake in the allocation process identified by the student representatives was corrected.

Judasa chairperson, Dr Karl le Roux, expressed their gratitude to SAMA's CE, Dr Percy Mahlathi and Industrial Relations head, Ms Pauline Legodi, for their assistance.

'It is a pity though that so much energy had to be used in trying to correct a process that should have run smoothly from the start. Nevertheless, Judasa is pleased that we have been active and effective in our watchdog role and have managed to effect change through the proper channels and without jeopardising the relatively good relationship with the Department of Health,' he said.

Le Roux emphasised that much remained to be done to alleviate problems with the community service



*Dr Karl le Roux*

allocation process. Judasa also wants to input into the HPCSA's two-year internship proposal. 'We are now looking forward to giving our full attention to these issues.'

**Magda Naudé**

flatlining?

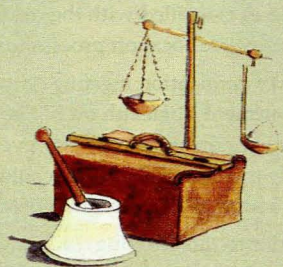


## The South African Medical Journal

### 100 years ago: Fifth South African Medical Congress address

In the toast of the congress, dwelling on the keen interest with which all such efforts were regarded by the mining authorities, and how pleased they were to have a gathering devoted to such high aims among them, Mr Eckstein deplored the assertion that those who had acquired much wealth on the spot became dead to any proposals for the general progress of the community around them, and he assured the gathering that so far from the truth was it that he, his fellow directors, and many others, were keenly alive to anything that promised substantial benefit to the mass of the workers.

(SAMJ, June 1899, Pg 42)



### 50 years ago: Prescription and dispensing

The chemists do not seem to realise that doctors are fully trained and licensed to dispense all medicines for their own patients. ...The 'pious clause' stating that 'there should be legislation to preserve for chemists the sole right to prescribe medicines, does not make sense. The chemists have never had the sole right of dispensing, much less prescribing. Only doctors should be allowed to prescribe for and treat patients, chemists may dispense prescriptions at the doctors' discretion.

...Further, to compare the sale of medicines by the 'little shops' of South Africa with that of Great Britain, is ludicrous when one considers the vast distances over bad roads which a great many country dwellers must travel to reach a doctor or chemist.

*Letter from 'Dispensing Doctor'.*

(SAMJ, November 1951, Pg 852)

## WINE AUCTION FUNDS AIDS HOMECARE



Delighted by the response at the Nederburg Auction were (from l-r): Bennie Howard (Nederburg Auctions), Professor J P van Niekerk (HASA Chair), David Douglas, (HASA Regional Director) and Dr Liz Gwyther (HASA Western Cape Chair).

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The Hospice Association of South Africa (HASA) received R260 000 towards its Development Fund from the 27th Nederburg Auction held in Paarl

including the establishment of 20 AIDS programmes focused on training township communities to become caregivers. Each programme will consist

recently, bringing the total amount donated by auction supporters to nearly R1.2 million over the past 11 years.

Eight unusual wines on the charity auction raised R258 200, with Nederburg Wines topping up the amount.

The latest donation will be used towards various development initiatives in HASA,

of ten paid caregivers with one professional nurse as a supervisor and one social worker.

HASA has also, in collaboration with the Department of Medicine at UCT, successfully motivated for a masters course in palliative medicine designed for experienced doctors who wish to gain expertise in the management of patients with non-curable and terminal illness.

The programme has been designed as a two-year, distance-learning programme using the principles of adult learning and includes practice-based learning techniques with practitioners specialising in paediatrics, oncology, geriatrics, etc.

'There is an urgent need for palliative medicine education in South Africa,' said Dr Liz Gwyther, Chairperson of



HASA Western Cape, a Medical Director of Helderberg Hospice and CEO designate of St Luke's Hospice.

The doctors complain that there are no palliative medicine journals available in our medical school libraries. There are only five doctors with diploma level qualifications in the whole country and no palliative medicine physicians.'

Last year Hospice used the donation to establish a diploma course in palliative care for nurses. Palliative care courses for nurses can be followed at the Cape Technikon - a one-year diploma or a two-year B Tech course.

In 2002 a six-month course will be available throughout South Africa. This training helps nurses assist patients,

especially cancer patients, to enjoy quality of life right to the end.

The highest bid at the charity auction was R200 000 for the biggest item - a 300 litre barrel of 2001 Nederburg Pinotage and the second most expensive was a collection of six special wines bought for R 33 000. The oldest item on the charity auction was a rare bottle of Madeira C1820 WS Boal Henriques & Henriques bought for R10 000.

## NEXT MONTH IN CME

In November/December CME, SAMA's continuing professional development journal for GPs, focuses on 'Travellers' Health'.

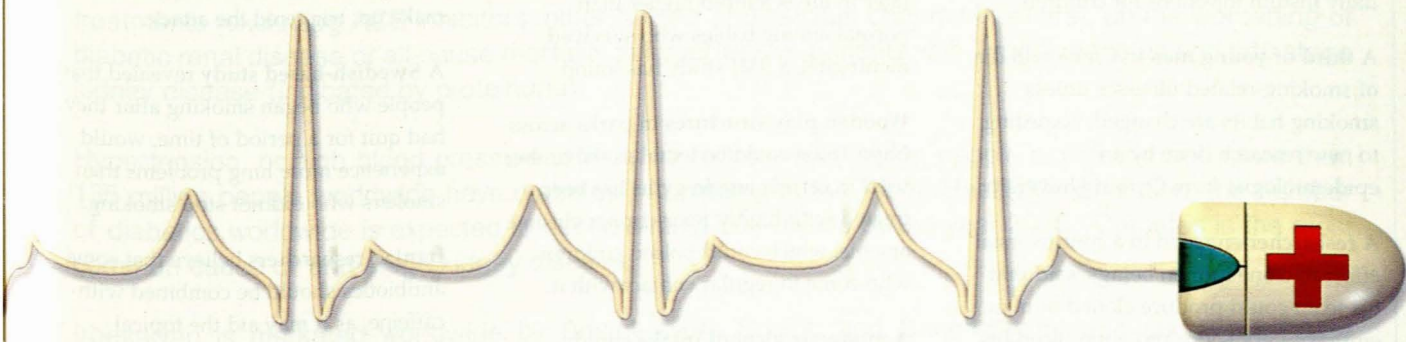
Topics include:-

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- What every doctor should know about malaria
- Problems with the high-risk traveller
- Challenges of travel medicine to the GP
- Disaster travel medicine: South African rescue missions abroad

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## ••• HEALTH DIGEST •••

**In the USA**, more children die of cot deaths than of cancer, heart disease, pneumonia, child abuse, AIDS, cystic fibrosis and muscular dystrophy combined.

**Latest statistics** revealed that one in every four overweight Hong Kong primary school children has a high blood cholesterol level.

**An experimental treatment** for advanced myelodysplastic syndrome, a rare form of leukaemia, could help prevent cancer patients from building up chemotherapy resistance, according to Glasgow University scientists.

**Czechoslovakian researchers** have found that beer may provide enough folate to lower the risk of heart disease.

**A five-year-old Malaysian boy** was apparently cured of a rare genetic blood disease resulting in chronic anaemia, after receiving blood from a baby's umbilical cord, by doctors believing that the transplant was a world first.

**A diabetes vaccine for children** will be tested in Sydney next year at the Centenary Institute, promising to end daily insulin injections for children.

**A third of young men** in China will die of smoking-related illnesses unless smoking habits are changed, according to new research done by an epidemiologist from Oxford University.

**A researcher** engaged in a controversial effort to clone human beings, said that his team could produce cloned human embryos very soon, and announced his plans to eventually impregnate up to 200 women with cloned embryos.

**Australian scientists** said they might have found a way to successfully treat

brain, nerve and spinal injuries by collecting adult nerve stem cells.

**A genetic characteristic** which distinguishes between primates and other mammals, would make humans technically easier to clone than sheep, cows, pigs and mice, Duke University researchers said.

**McDonald's fast food chain** now supplies information on their website about ingredients after vegetarians complained the group fries potato chips in animal fat.

**Failure to remember** anniversaries and telephone numbers is not confined to the elderly, according to a US psychologist, who claims that performance in various memory tasks deteriorates steadily from the mid-twenties age group.

**Patients who suffered heart attacks** could avoid second attacks by 30% if they took leech saliva which, according to international findings presented at a cardiology conference in Sweden, was more effective than modern drugs.

**The risk of developing disabilities** later in life is tenfold higher than normal among babies who survived meningitis, a *BMJ* study has found.

**Wooden play structures** in parks across Cape Town could be lethal as the timber used in certain jungle gyms has been treated with highly toxic copper chrome arsenic, which could poison children who come in regular contact with it.

**A moderate alcohol intake** could reduce the risk of some types of strokes, but it could also reduce the size of the brain among Alzheimer sufferers, according to Harvard Medical School.

**As a result of the terror attacks in the USA**, children are experiencing shock linked to vicarious traumatising and a well-known psychologist has advised parents to discuss their children's fears with them.

**Cellphone usage** over ten years increases the risk of brain cancer by 26%, but over a longer period that risk can rise to 77%, latest studies have shown.

**A British biotechnology firm** confirmed that they would be testing a new smallpox vaccine for the USA soon after heightened fears of biological warfare after the recent New York terror attacks.

**Local paediatrician**, Dr Johan Smith, and a German specialist are among those researching new methods of artificial respiration for babies, hoping it will significantly decrease lung illnesses in infants.

**After suffering breathing problems** while kissing his wife goodbye, an Italian man went into anaphylactic shock after his allergy to cereal, a basic ingredient contained in his wife's make up, triggered the attack.

**A Swedish-based study** revealed that people who began smoking after they had quit for a period of time, would experience more lung problems than smokers who did not stop smoking.

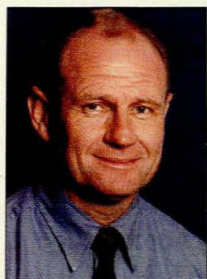
**Iranian researchers** believe that some antibiotics should be combined with caffeine, as it may aid the topical treatment of local infections which are resisting antibiotics.

*From MediaScan, IOL and other sources.*



## NEWS

### PICK 'N PAY INVESTIGATES PHARMACY SECTOR MOVE



Pick 'n Pay CEO, Sean Summers.

Pick 'n Pay has been researching the feasibility of competing with the New Clicks entrant into in the pharmacy sector for almost a year, and expects to make a final move within months.

Pick 'n Pay CEO, Sean Summers, said the group has a long track record in franchise, with a chain of over 100 franchise stores, while Clicks is a relatively new entrant.

He said he believed pharmacists are best suited to own, operate and manage pharmacies. Summers felt that a pharmacy franchise model would bring about more competitive pricing, good service and a seamless interface with medical aid schemes.

Customers should benefit from their proposed combination of professional pharmacist ownership and control and the retail giant's infrastructure and expertise.

Valumed has agreed to use its Gauteng store as a pilot project to test some of the retail concepts. Valumed looks set to become one of the first franchisees, depending on the success of the pilot initiative and on receiving approval from the SA Pharmacy Council. Pick 'n Pay is meanwhile broadening its investigation currently 'focused on the legal and commercial basis upon which a viable entry would be possible.'

### MEDSCHEME ACQUIRES SANLAM



Medscheme CEO, Anton Roux, Sanlam Health CE Johan du Preez and Sanlam CEO, Leon Vermaak.

Both parties are hush on the price Medscheme paid to acquire Sanlam Health from the Sanlam Group, subject to approval by competition authorities.

Dr Leon Vermaak, Sanlam's Chief Executive, said the deal was not material relative to Sanlam's market value but would 'unlock capital for Sanlam' and not negatively affect its profit'.

He explained that Sanlam Health was relatively small in comparison with the Sanlam Group's overall business and could better serve customers as part of the larger Medscheme arrangement.

He predicted a smooth transition and said it would not impact on members' benefits once the deal is finalised.

Medscheme Chief Executive Anton Roux said that they were 'not only acquiring the administration and managed care contracts for Topmed and Selfmed's 45 000 families', but also the expertise of all 250 Sanlam Health employees as well as value-added services for Transmed, LAMAF, BESTmed, Munimed and other schemes.

### ASPEN RAISES NET PROFIT 78%

The largest JSE-listed pharmaceutical company and generics manufacturer in South Africa, Aspen Pharmacare, continues to cling to its top position.

Turnover increased by 18% to R1.12 billion and strategic changes should maintain this positive trend, said CEO Stephen Saad. He said that their 'realignment process' had also equipped them to benefit from legislative changes in favour of increased generic use.

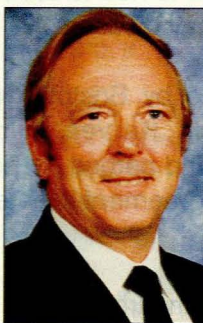
Net profit to shareholders grew by 78% to R178.9 million. Headline earnings per share rose 43%, while operating profit from continuing operations before amortisation rose 41% to R298.5 million. He said that 'we are targeting an increase in headline earnings per share in excess of 25%'.

Saad was particularly pleased with performance following the resolution of Kinesis. He predicted that the newly-launched non-narcotic analgesic, Mybulen, could become one of Aspen's leading brands and had 'already delivered sales far exceeding management's expectations'.

It had closed strategic deals with multinationals including AstraZeneca, Schering and Almirall Prodesfarma, and had increased strength in natural products by its acquisition of the Formule Naturelle range. Saad highlighted that they had managed to secure an increased number of state tenders.

He said the company had signed agreements with international companies to access the active pharmaceutical ingredient required for most HIV/AIDS antiretroviral cocktails and Bristol-Myers Squibb had recently authorised the company to use their patented molecules. It was thus well positioned to 'play a meaningful role' in response to the AIDS epidemic.

### GPNET AND DEDICARE MERGE



Lex Visser, CEO of Dedicare.

GPNet and Dedicare joined operations last month. The organisation, which will operate under the name GPNet, will represent the interests of some 2 000 GPs in private practice.

The share exchange scheme through which Dedicare would become a wholly owned subsidiary of GPNet, will be wound up within six months. GPNet will continue to strengthen itself as a GP network while Dedicare will mainly handle risk management contracts.



## SCHEME PREMIUMS TO ROCKET

The Council for Medical Schemes has consistently scorned industry fears that the new Medical Schemes Act would force them into bankruptcy.

However, Global Credit Ratings (GCR) Director Jonathan Behr, said their latest well-respected research showed the solvency rate of existing medical aids was set to deteriorate even further. Therefore GCR lowered its maximum rating for medical schemes from A to AA minus. Behr felt that because of the risky state of the industry, no 'scheme would qualify for a rating higher than the low rating of AA minus'.

Industry analysts have shown that 10% of South African medical aid schemes are rated as having 'uncertain claims paying ability' - compared to none two years ago. The respected Old Mutual annual survey predicted that rising administration costs and medical inflation could see even subsidised employees spending a third of their salary on premiums within the next ten years. A third of companies surveyed planned to offer no medical aid retirement benefits to new employees.

This year, six medical schemes have already implemented premium increases in January and July. Industry leaders, including Anton Roux of Medscheme, predict that tariffs are likely to rise by between 15% - 25% next year. This is likely to lead to more amalgamations and schemes buying their own pharmacies to keep membership affordable. The situation is not helped by the falling value of the Rand which has been a major cost factor for hospitals and practices importing equipment.

Calling for calm, Council Registrar Patrick Masobe responded that actually less than 5% of all registered schemes had posted poor results, while the rest all met the statutory solvency required level of 10%. According to Masobe, open schemes' membership grew by almost 8%, with closed schemes faring better at just over 16%.

Registered schemes had experienced growth of about 10%, restricted schemes grew 16.4% and open schemes posted a 7.7% growth figure.

He said the 26% hike in administration costs per beneficiary was largely to blame for an overall 7% increase in gross contributions, and that brokers also pushed up costs as they 'were being paid large amounts to do nothing but churn members from one scheme to another'.

Claims had increased by only 6%. 'When you link the change in fees to the actual claims per beneficiary per month, you can't justify the larger fees', he said.

The Council survey showed that a 32% increase in administration costs was found among open schemes, while restricted funds posted a 14% rise.

He also shared the concern that 11 of the 16 open schemes with a solvency ratio of below 10% (out of 47 open schemes studied) had shown losses of more than R207 million because of reinsurance abuse.

A report by the Department of Health backed up Masobe's argument, stating that 'it is premature to assess the impact of the Act, but certainly it has not resulted in a flight of members from medical schemes...Similarly, allegations that the Act is the major cause of cost escalation are clearly unfounded.'

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## AFRICAN LIFE ACQUIRES INGWE



Ingwe MD, Peter Botha.

The acquisition of Ingwe Health Plan Organisation by African Life in August is aimed at allowing the medical scheme to utilise the resources of the established financial services group. The Ingwe brand will be retained.

Jeremy Rowse, CE of African Life, said the move made business sense and forecasted synergies are already taking place. He said that key management had remained in place and been properly incentivised. He said Ingwe would now be better equipped to take advantage of the 'largely untapped South African market' and can expand into other African regions where African Life has existing operations.

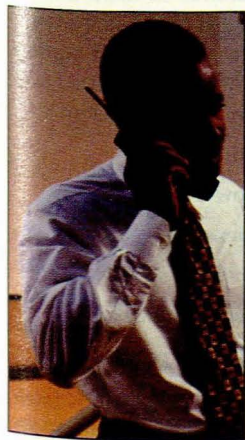
Ingwe HPO aims to double membership growth within three years, according to MD Peter Botha. As the market leader in fourth-generation capitation products, Ingwe was the only medical scheme that could manage more than one capitated network of primary care providers.

## INFORMATION TECHNOLOGY

### ASSISTING COMPLIANCE THROUGH INNOVATION

By David Green

*'In some respects, adherence is like the weather: everyone talks about it but no one seems to do anything about it.'* BA Boyle.



Non-compliance with prescribed medication is a constant problem for health care systems. In practice, not a day goes by in which there isn't the frustration of a patient who would clearly benefit from taking their medication as prescribed, but who is simply not taking it.

Non-compliance is however a bigger problem than simply a frustration at the coalface of clinical practice. It has been shown that non-compliance causes about 125 000 deaths in the USA each year. In

addition it leads to anywhere between 10% and 25% of hospital and nursing home admissions. The costs of this are astronomical - US\$ 31.3 billion in nursing home admissions and US\$ 15.2 billion in hospital admissions per year. While the

figures are not known for South Africa, it is certain that non-compliance is costing the health services a significant amount of money.

The costs of providing medication to people living with chronic diseases are substantial. However, these costs can be justified in terms of the benefits to the patient in improved quality of life, to the funder in reduced overall case management costs, and to society in increased productivity and longevity. It is in the area of chronic medication where compliance is at its worst, some estimates put non-compliance at 60%.

In essence, significant levels of compliance in individual patients result in a cost shift from inpatient utilisation and the costs associated with the treatment of adverse effects of untreated disease, to the costs of the medication, with a net saving.

A number of reasons have been put forward for non-compliance. These include psychosocial issues and side-effects of the medication. However, several studies have found that a major reason for missing doses is simply that patients forget to take the medicine.

#### Strategies for improving compliance

A variety of tools have been previously used to remind patients to take their medication. Some have proposed various beepers and alarms - but in practice these devices carry the risk of not being on or near the patient at the time of the reminder and have been shown to not be effective in improving compliance.

However, people tend to carry their cellphones with them and are more likely to have the phone with them at the time of the reminder. In addition, the cellphone provides a readily available means of asking questions, reporting problems, generally gaining assistance or providing feedback at the time that the medication needs to be taken. The interactivity between the patient and the organisation reminding the patient to take their medication makes this service more acceptable to patients than simple alarms or beepers. In addition the cellphone carries no stigma with it, while a custom device can do. Over 11 million South Africans have cellphones, indicating that cell phone usage is wide spread amongst South African adults.

A compliance service using the SMS network started in South Africa some eight months ago and has since expanded to Australia. Most users in the United States still use analogue phones and thus cannot send SMS, and Europeans have still not used the technology for health uses such as ensuring regimen compliance. So South Africa may well be on the cutting edge with this one!

Dr David Green runs 'The Compliance Service' which uses an SMS alert for chronic medication compliance. He also writes the monthly 'Green Report' on IT issues at [www.green.za.net](http://www.green.za.net).



## PRACTICE MANAGEMENT

### WHEN THINGS GO WRONG...

Research by Murray and Neil Raphel studied why customers quit a business. They found that two main reasons were the following: 14% of customers quit because they were dissatisfied with the product or service. A massive 68% left because of indifference displayed by some, or even just one, employee.

But how do disappointed patients react? For sure, the majority don't say anything. In fact, it is estimated that less than 1% of unhappy customers actually complain to someone who can do something about it.

#### Why do most customers not complain?

- They don't believe that they will get any satisfaction.
- It is embarrassing and uncomfortable for them. They don't want to make a scene, or appear to be difficult, or to hurt someone's feelings. They may also not want to embarrass their spouses/kids/colleagues/other patients.
- They feel intimidated by the staff, or by the success and reputation of a practice.
- It is just too much trouble. They feel that they may be pushed from pillar to post, or asked to fill in forms, etc.
- They are aware that they can simply go somewhere else (and they do!)
- It takes time - they may be in a hurry
- If you are lucky, they may give you another chance. (But mentally file the bad experience in their minds).
- Of course, they can fill in a written complaint. These could take the form of one of your questionnaires. The problem is that by the time you get them back, it's too late. Therefore, a quick response is absolutely essential. If possible, telephone the patient. If not, write as soon as possible, but do respond, even if they ask you not to.

#### How do patients complain?

- It depends on the size and type of the problem, the personality of the complainant and whether the people in the practice are approachable.
- In most cases, because of previous experiences, some patients who actually say something, do so defensively. They are apprehensive, and possibly also angry, and therefore communicate aggressively rather than reasonably and logically. The emotions need to be handled first before you can get anywhere.
- Other patients will almost casually throw out clues that something is wrong. Some may use a questioning technique, e.g. 'How long do I have to wait?' in order to make sure that they have all the facts before they start complaining. If you ask if something is wrong, some will first deny it or down-

play it. Yet others may blame some external elements, or even themselves, for the problem.

- If you are fortunate, a few complainers will in a straightforward, open and understanding manner explain what the problem was. If they are poorly handled, in spite of their own positive style, then you are in trouble.

#### Why do patients get upset?

- Their expectations have not been met
- They don't feel listened to, feel ignored
- They don't want to lose face, be put down or shamed
- They feel other patients were treated better
- They are tired, frustrated, or stressed
- They feel powerless, out of control
- No-one will listen unless they make a scene
- They have a chip on their shoulder
- Someone might have made a promise that was broken
- They think your advertising is misleading
- Someone was indifferent, apathetic or even discourteous
- They were told different things by different people
- They were given wrong information
- They are prejudiced, even for the strangest reasons
- The 'rules' are more important than they are
- They feel they can manipulate you if they make a scene
- They are suspicious, and think you are dishonest
- They got caught out (in a lie, or similar)
- They made a mistake but are too embarrassed to admit it
- They made a wrong assumption about your company
- They are told they have no right to be emotional
- They hate 'big deals' and 'smart-asses'
- They are transferred from person to person
- Their integrity and honesty have been questioned
- They think that people, or the practice, are incompetent
- They have been delayed, or kept waiting
- No-one has gone back to them to follow-up
- They expect some restitution or compensation
- No-one apologised
- They want someone to be reprimanded or punished
- They feel that you haven't done anything to prevent recurrence.

Remember that if they do not complain, it does not mean that they do nothing. They react in other, more damaging, ways. The 'nice' patients who don't complain can be your biggest danger.

But perhaps most importantly, most of the silent ones are willing to share their disappointment and resentment - but only



if they are asked properly. Practitioners need to be able to come up with as many ways to answer the question: 'How can we get our patients to talk to us?'

Before anything else, your own attitude towards criticism, whether valid or unjustified, needs to be challenged. If you don't want the feedback, then don't deal with patients. You need to look out for the verbal and non-verbal clues that they give you that indicate their disappointment. Be warm and empathetic, open and accommodating. Make sure that you let them know that you want their feedback, that you know that things don't always go the way they should, and that they won't be hurting anyone with their criticism.

It is therefore possible to make the following points about the sometimes whining and aggressive complainers:

- They are by far in the minority of dissatisfied patients.
- They do not necessarily represent the views of all patients, nor do their problems necessarily represent the problems of all patients, but they can lead you in the right direction.
- If poorly handled, complainers will react far worse than non-complainers, and will make a scene. But, if properly handled, and the problem is resolved to their satisfaction, the complainers are far more likely to return. They will also probably tell other people how the problem was solved.

So the patient who complains is actually your loyal customer, because he is giving you another chance to delight him.

The reality of the situation may have absolutely nothing to do with the way the patient perceives the problem. But the perception, for him or her, is the reality, and that is what you need to be able to manage. The outcome of the interpersonal encounter is at least as important as the actual resolution or elimination of the problem.

### How do you manage negative feedback?

None of the behaviour described is about objective, logical, rational, unemotional human beings. This is especially true of patients who are already fearful and upset by the possibility of disease and death.

Patients go through 'The Three R's' when they are upset. If the problem is not resolved in the first stage of Resistance, the patient moves onto the next stage and becomes angry and Resentful. But if there is still no solution in sight, they will find creative ways to take Revenge on you or the practice.

### So what can you do?

Your practice needs to adequately answer the following:

- Why don't most of our patients complain? What can we do about that?
- Do we make it easy for our patients to complain?
- Does everyone in the practice fully understand all the consequences of having dissatisfied patients?
- Do we really know our patients' expectations and needs?

- How often do we deliver more than their expectations? How often do we deliver less?
- Have we adequately identified all the things which upset our patients, and taken action to prevent recurrence?

### The practice's generic response

Five elements are essential for the recovery process. In no particular order, these are:

- The situation should be resolved as quickly as possible, and as close to the source as possible.
- Concern and empathy must be displayed in the solutions.
- Display awareness of the short- and long-term implications from a patient's perspective.
- Rectify the mistakes and follow-up so that patients do not feel they have lost anything of value. This may need to include some form of compensation or atonement. Then follow-up to ensure that the practice did in fact deliver the promised rectification, as well as that the patient is happy with the result.
- Finally, take preventive steps. Take action internally to ensure that this problem does not repeat itself, but also ensure that the problem is monitored and remains solved.

When dealing with a problem or complaint, an easy way to remember how to ensure the right response is to use the acronym LEAP: Listen, Empathise, Apologise, and only then Problem-solve.

*This article is the second in a series drawn from notes of the Foundation for Professional Development's course 'Certificate in Practice Management'.*

## SAMA SUMMIT VIDEO

A half-hour video production on SAMA's groundbreaking 'Summit on the Future of Medicine' held in Johannesburg in March is now available from our Publishing Division.

This fascinating and thought-provoking mini-documentary covers topics as diverse as how future doctors should be recruited and trained to address resource inequities, to the Human Genome Project and racism in the profession.

The video offers a fascinating insight into what South African leaders in health care are thinking and planning.

The Summit video is available at its cost price of R50 (postage and VAT included) from Edward MacDonald at telephone (021) 530 6528.