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Number 19 April 1987

PRIVATISATION

Health at a price

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Contents

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Editorial

Control over health services in South Africa has shifted from the state during the 1960's and 70's, towards the private sector since 1980. The trend towards privatisation of essential services was precipitated by the economic and political crisis, by unfulfilled promises made to Coloured and Indian voters in the 1983 constitution, and by the boycotts of state-administered services (education, housing, transport) in the black townships throughout the country.

Privatisation is broadly defined as the total or partial transfer of state-provided or administered services to the private sector. Privatised health care effectively amounts to a curative service available in proportion to income.

Arguments in favour of privatisation stress the importance of cost containment and cost-efficiency in health care delivery. The privatisation lobby promises more efficient services that would not cost the state much; fees payable by the patient are supposed to act as disincentives for "overutilising" health services.

Opponents of privatisation argue that privatised health care is care for vested interests, not health needs, and that privatised health services do not provide the whole spectrum of health care.

This issue of **Critical Health** does not profess to provide a comprehensive review of the privatisation debate; rather, it attempts to place this debate in its political and ideological context. The aim is to popularise the issue of privatisation, so that it can be addressed by those whom it most concerns.

The first article, *The Politics of Exclusion*, establishes the historical and political link between privatisation and the 1983 constitution with its extremely fragmented services, the National Health Policy Council, and the new regionalisation programme. *The Ideology of Privatisation* examines the Report of the Commission of Inquiry Into Health Services, and the three-tier health system (state, private, and community services) it proposes for different income groups. It is private hospitals, practitioners, and the pharmaceutical industry that stand to gain from such a health care delivery system - though in different and sometimes contradictory ways. This is shown in the article *Privatisation: The Various Interested Parties*. The state also stands to gain from this proposed health

care delivery system: The abolition of centrally administered state health services entails a depoliticisation of health care. State health officials hope that with privatisation, the state will no longer be seen as responsible for the provision of appopriate and adequate essential services.

Privatisation initiatives coincide with various other state moves to alleviate the political and economic crisis. Deregulation of small businesses, for example, represents a corollary to privatisation. Deregulation implies that the state exempts small businesses from certain minimum social security requirements pertaining to workers. The article on occupational health services outlines the present role of the state, management, and workers in the provision of social security, and suggests some alternatives to the present system.

Cut-backs in the state's expenditure for those health services which it will continue to administer, are another corollary of privatisation. The article on TB screening in industry argues that the assumption of cost-inefficiency, on which the cut-backs in this case are based, is based on an incorrect premise.

Most proponents of privatisation fail to take into account the hidden social costs which will escalate if health care becomes beyond the reach of the majority of people. Research on this aspect of privatisation and on the fee-for-service payment structure has shown that the increase in provincial hospital fees has resulted in a drop in day hospital attendance with an increase in hospital admissions. This indicates that low-income patients suffering from chronic illnesses cannot afford to pay the cost of regular outpatient treatment and, as a result, are admitted to hospitals in larger numbers. Worst hit are low- income patients who are denied access to both public and private health sectors, as they can afford neither hospital fees nor medical aid coverage.

Progressive health organisations have responded to privatisation proposals by calling for a national health service. They argue that privatisation does not address the health care needs of the majority of South Africans, and that it therefore should not be seen as a step towards health care for all.

The politics of exclusion: fragmentation and depoliticisation of health services

The concept of privatisation was first mooted in 1983, when the new constitution was passed, enshrining the principles of "private initiative and effective competition".

The privatisation debate gained further momentum when new policies on regional services were formulated in 1985. The fact that privatisation and the politics of regionalisation seem to go hand-in-hand is not mere co-incidence. Privatisation and regionalisation - fragmentation along ethnic and class lines - produce the same ideological effect. Both of these policies serve to remove the struggle for adequate and appropriate social services from the political arena. Fragmentation of health services appears to pave the way for privatisation, as it produces exactly the bureaucracy and cost-inefficiency which the proponents of privatisation cite as a rationale for privatising health services.

The following article traces some of the political developments leading to the fragmentation of services generally, and health services in particular.

The 1983 Constitution

Under local and international pressure to incorporate "non-white" population groups in decision-making, and to curb urban unrest over inequalities in the

allocation of resources, the South African government passed a new constitution in 1983. The most important features of this constitution are the following:

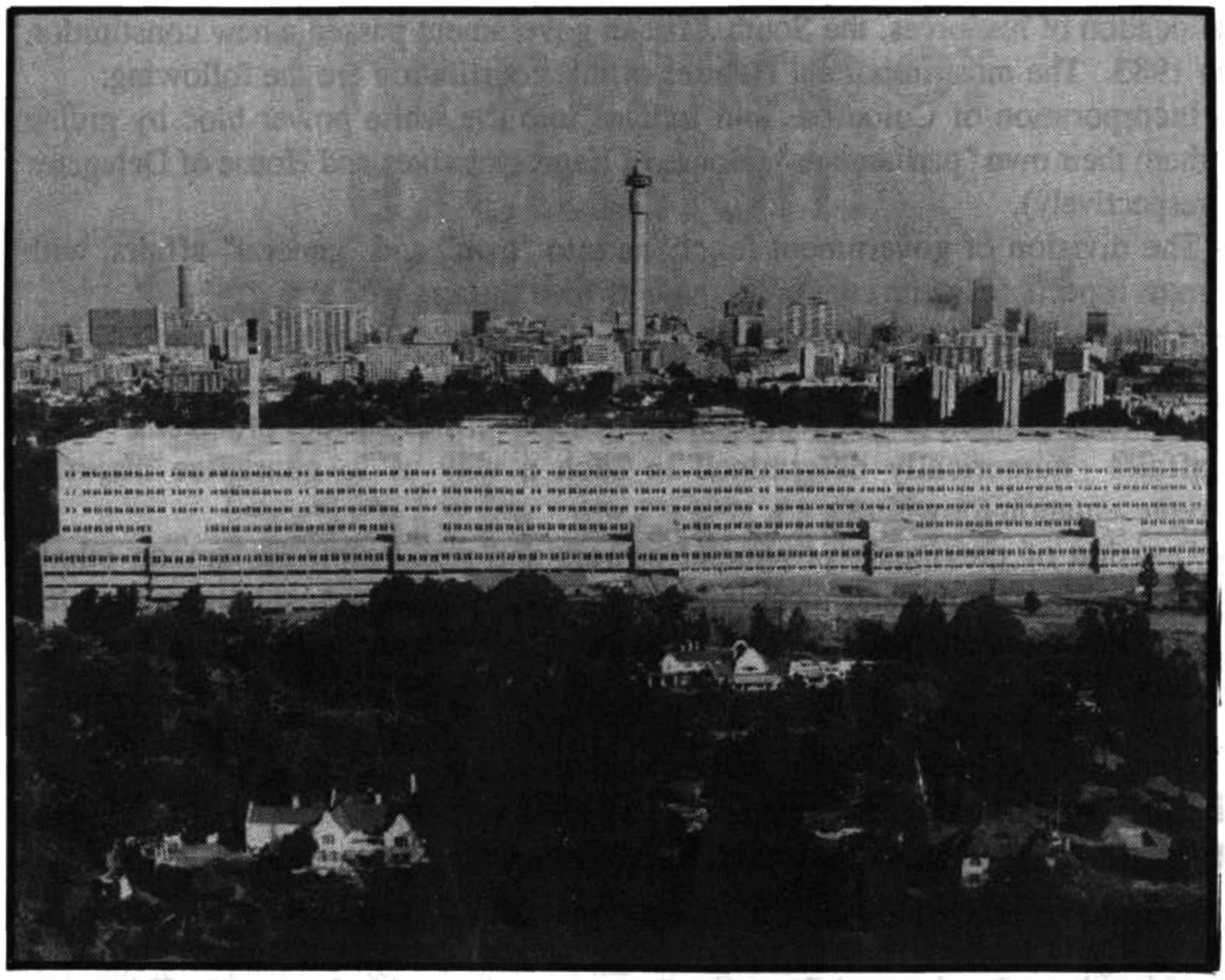
- Incorporation of Coloureds and Indians into the white power bloc by giving them their own "parliaments" (House of Representatives and House of Delegates respectively).
- The division of government functions into "own" and "general" affairs, with most aspects of health care falling under "own" affairs.
- "Own" affairs "controlled" by ethnically defined parliaments, local authorities, and the growing ethnic bureaucracies.
- Representation on bodies dealing with "general" affairs and co- ordinating "own" affairs numerically determined in such a way as to guarantee majority representation for whites.
- Division of previously provincial powers and responsibilities among ethnic rulers on a national and local level. This meant moving hospitals and related services from the provinces to the new ethnic health departments and local authorities.

Fragmentation of health service under the 1983 Constitution

Most health matters were placed under the three "own" affairs departments. A health policy planning and financing department, located in "general" affairs, was also proposed. This resulted in four departments of health. In addition, each of the ten bantustans contributed their own Department of Health. There were thus 14 Departments of Health within the Republic of South Africa (including "independent homelands"). This excessive fragmentation resulted in multiplied costs, and has been criticised in the more recent privatisation moves and in the statements released by the National Health Policy Council.

Crisis in the financing of health services

One of the aims of the Constitution was to incorporate Coloureds and Indians in limited decision-making. However, to put the newly established structures into practice, the state would have had to deliver certain material benefits to these groups. Financial resources, according to the Constitution, were to be allocated in the following ratio: Indians 1; Coloureds 2; and whites 4. This promised allocation of funds however, was not fulfilled. The costs for whites' "own" affairs exceeded this ratio. Limiting this excessive cost would have meant closing down certain white provincial hospitals.



Limiting the costs of services for whites would have meant closing down large provincial hospitals

Crisis in the State's political legitimation

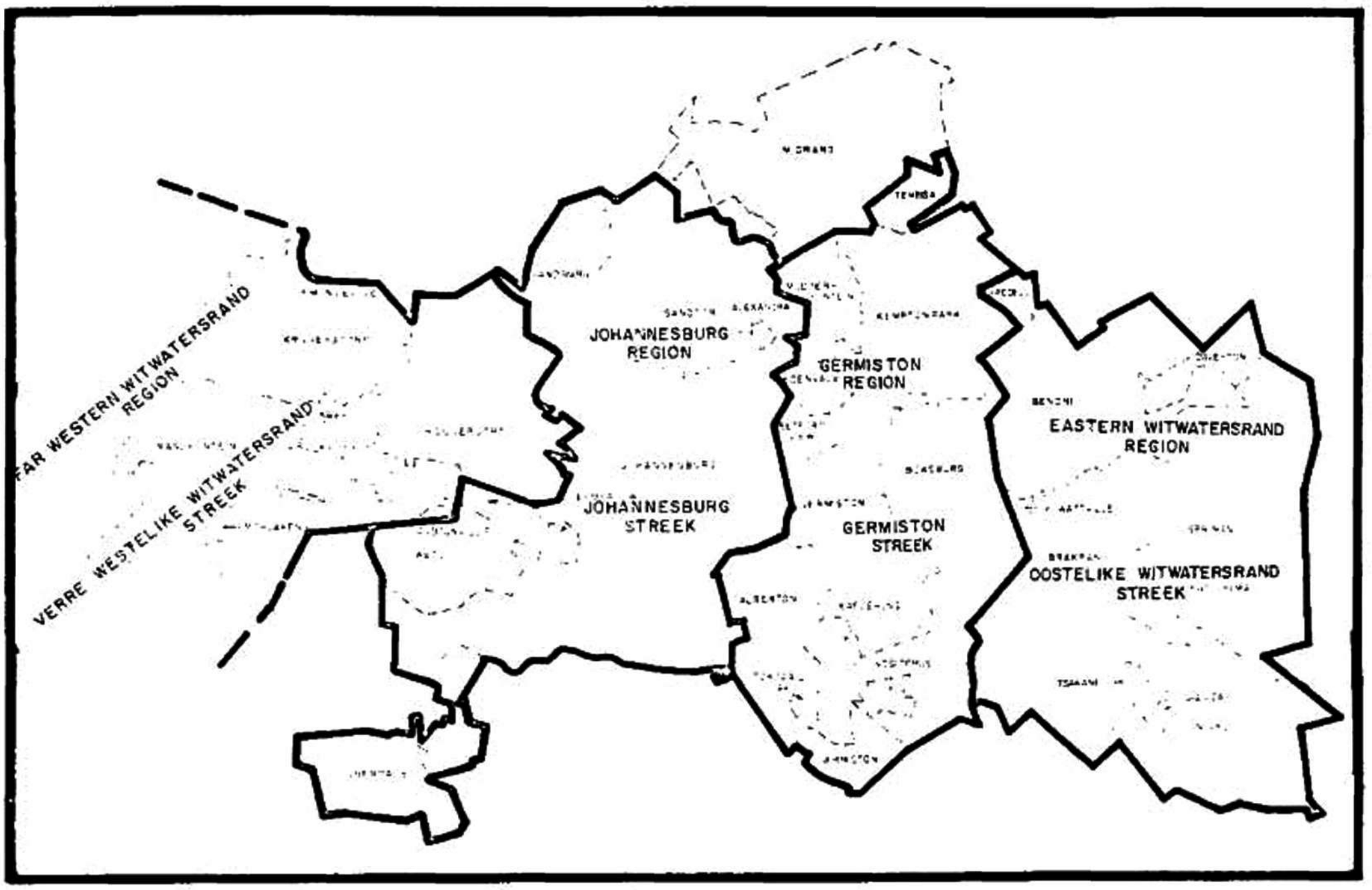
The fiscal crisis at this time co-incided with a crisis of political legitimacy. Township protest revolved around local authorities' structures and jurisdiction, housing, education and welfare services. It was clear that black township dwellers would not accept political rights at a local level without central state representation. In an attempt to stem the process of losing control over township administration, the state proposed strategies to de- politicise and de-racialise social issues. Authority over welfare services was to be handed over to regional and local government and, as far as possible, the provision of these services was to be handed over to private companies. These proposals were adopted, and the government accepted the notion of "decentralisation of welfare functions, centralisation of order functions". The government is thus prepared to relinquish central control over "soft" services, while reaffirming its hold on key functions such as "law and order".

Regional services councils

By 1985, new administrative spatial units had been proposed to disorganise opposition and to effect de-politicisation. It was decided that the whites-only, centrally dominating category of "general affairs" would be administered by "Regional Services Councils", concerning policy, finance and budget control functions. (The ethnically segregated local authorities would continue to handle "soft services" that go under the label of "own affairs".)

Although areas have been demarcated for Regional Service Councils, the process of implementing them has not yet been completed.

Regional Services Councils throughout the country are to render services on a regional basis, and will be financed through taxes levied on businesses. This means that larger municipalities with higher tax contributions will be able to control these Councils. Members of these Councils are appointed (not elected) from previous segregated municipal councils. They are thus not answerable to any group of people, and are likely to represent powerful business interests. The principle of representation on the basis of tax contributions almost automatically limits the number of representatives from black township and rural groupings serving on the Councils. Consequently, any black members of the Councils will not be able to win the majority that is required for any decision.



Demarcation Board boundaries for the Witwatersrand RSC's

The new national health dispensation

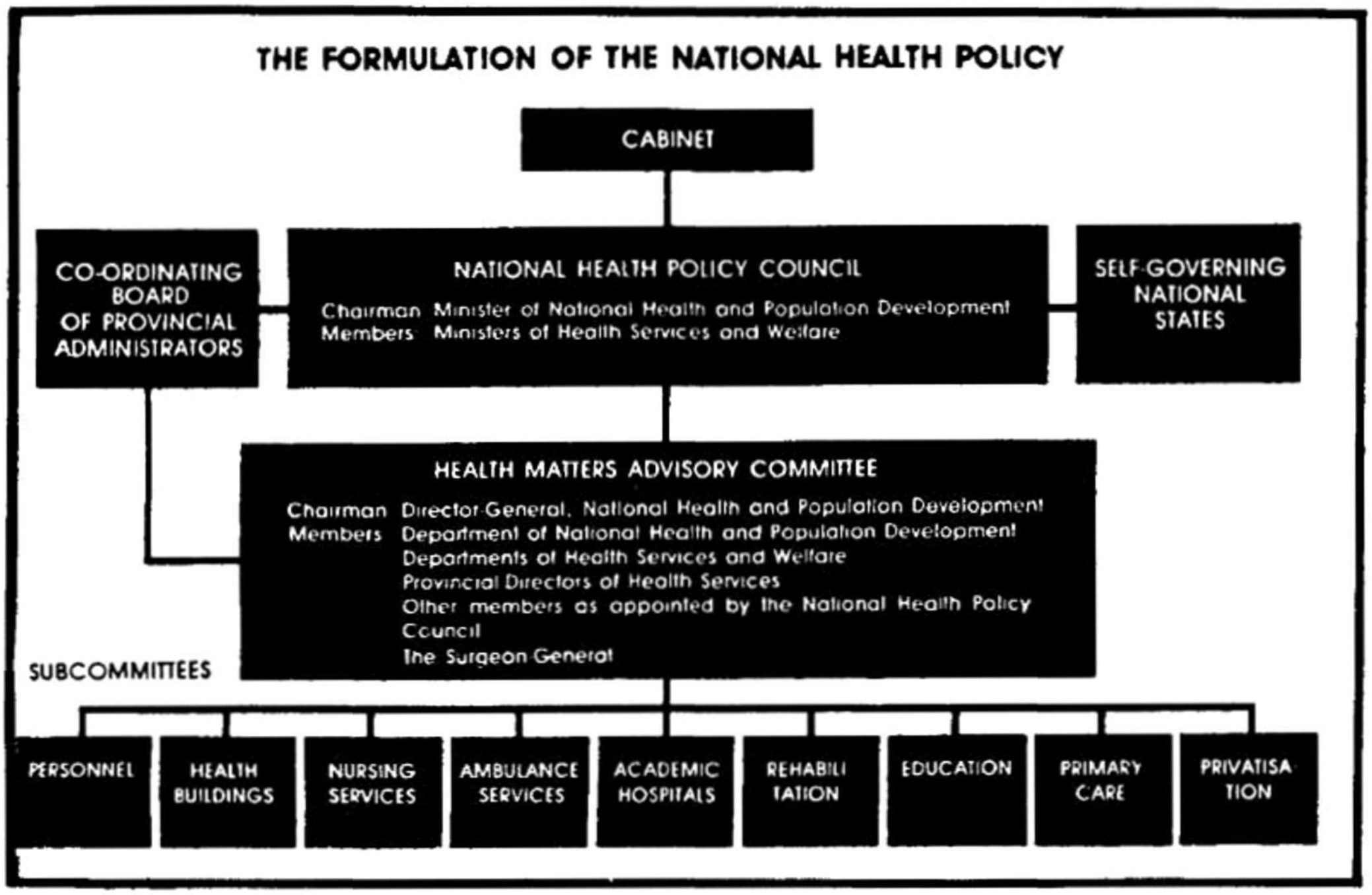
Co-inciding with the demarcation of Regional Services Councils, a new national health dispensation was announced in August 1986, after much confusion over the question of which hospitals fall under "general" and "own" affairs. The new policy on this question did not bring about the dismantling of apartheid in hospital services. Hospitals are divided into the categories of "general affairs" (teaching hospitals and those occupied by less than 80% of one race) and "own affairs" (hospitals with 95% single race occupancy). Ethnic hospitals under "own affairs" are administered by the provincial authorities who, in turn, are accountable to the particular ethnic chamber of parliament.

Minister of National Health and Population Development, Dr W van Niekerk

The National Health Policy Council (NHPC)

The National Health Policy Council, headed by the Minister of National Health and Population Development, is to decide on policy, and to co-ordinate, plan, and monitor health education and primary health care. This Council also advises the government on the financing of health services, and includes the three Ministers of Health from the Houses of Assembly, Representatives, and Delegates. It excludes blacks living outside of "independent homelands". "Independent homelands" are supposed to liaise with the NHPC on health matters. The Department of National Health and Population Development is to provide services for black communities, delegating execution to provincial administrations.

Thus health matters fall under a separate council, distinct from the Regional



The structure of the National Health Policy Council as announced in August 1986 .

Services Councils. While the regional policies leading up to the formation of the Regional Services Councils can be seen as an inadequate response to the crisis of legitimacy of local government structures, the new national health dispensation (including the National Health Policy Council) does not even pretend to address popular demands for adequate and appropriate social services. The new health policies rephrase and re-enact the fragmented, unco-ordinated health services, by excluding blacks from any national health policy, and by excising "homeland" health services from central control.

Conclusion

Fragmentation of health services into health departments of various "homelands", "general" and "own affairs", and into central state, provincial and local authorities, as well as the nine Regional Services Councils, is being challenged by the Health Charter Campaign and by the growing popular demand for a National Health Service. These campaigns are not being carried out in a vacuum. They follow moves to establish alternative local government structures. Thus the state's "regionalisation" programme for the provision of essential services has been met with resistance, and alternatives have been put forward by those whom this programme is trying exclude.

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The ideology of privatisation: self-help and victim-blaming

There has been much debate around the financing of health care. Proponents of privatisation recommend private health care for those who can afford it. Those who cannot afford it, will have to live by the official rhetoric of "community, primary and preventive health care", although these services are almost non-existent in many areas. This article spells out some of the implications of the class-discriminatory health care delivery system proposed under the banner of "privatisation".

"The individual is responsible for his/her own health"

At the 5th GP Congress in Johannesburg in April 1986, Dr A Snyckers, president of the Pharmaceutical and Chemical Manufacturers' Association, laid down the following premises for containing the costs of health care:

- The individual is responsible for his/her own health
- Access to unlimited free health care is a privilege, and not a right
- There must be a unitary health care delivery system
- The individual, rather than the institution, should be subsidised. The level of state subsidisation should be tied to the level of income or the taxation paid by the individual
- User charges should be levied
- Medical aid schemes should be restructured, over-usage of the health services should be curbed, and a more market-oriented health care delivery system should be developed.

Myths about health and ill-health

The assumption that people are responsible for their own health is not new in South Africa. It has been cultivated for a long time in official investigations and reports, and has given rise to a series of myths on health and ill-health:

- If people get cholera, it is because they do not use safe, chlorinated water
- If children are malnourished, their parents do not feed them properly, or they have more children than they can properly look after.

These myths have been debunked by progressive health workers and sociologists. People do not choose to live unhygienically; they are condemned by political and economic factors to live in areas and circumstances where healthy living is impossible.

Myths like the ones quoted above have been created to remove health issues from the political arena. They obscure the relationship between widespread ill-health and exploitation, and they focus attention away from the role of the state and employers in health and health care delivery.

Victim-blaming

Such deflection of responsibility is particularly clear in the victim-blaming approaches adopted by employers and employers' associations when it comes to issues of occupational health and safety. In the cases of many accidents, workers' injuries are blamed on their own carelessness or neglect of safety precautions.

This victim-blaming approach is captured for instance in the National Occupational Safety Association's contention that 88% of work-related accidents are caused by the workers' "unsafe acts"; a further 10% are acknowledged to be caused by unsafe working conditions, and 2% are attributed to "acts of God" or "misfortunes". On the mines, management seeks to prevent accidents by admonishing individuals to "work safely".

As mentioned earlier, the approach that makes the individual responsible for his/her own (ill) health has been around for a long time. However, under the current privatisation moves, this approach is being revitalised, extended, and is aquiring a new econcomic, social, political and ideological significance. It also serves as the basis for concrete practices and policies on the part of the state and private enterprise.

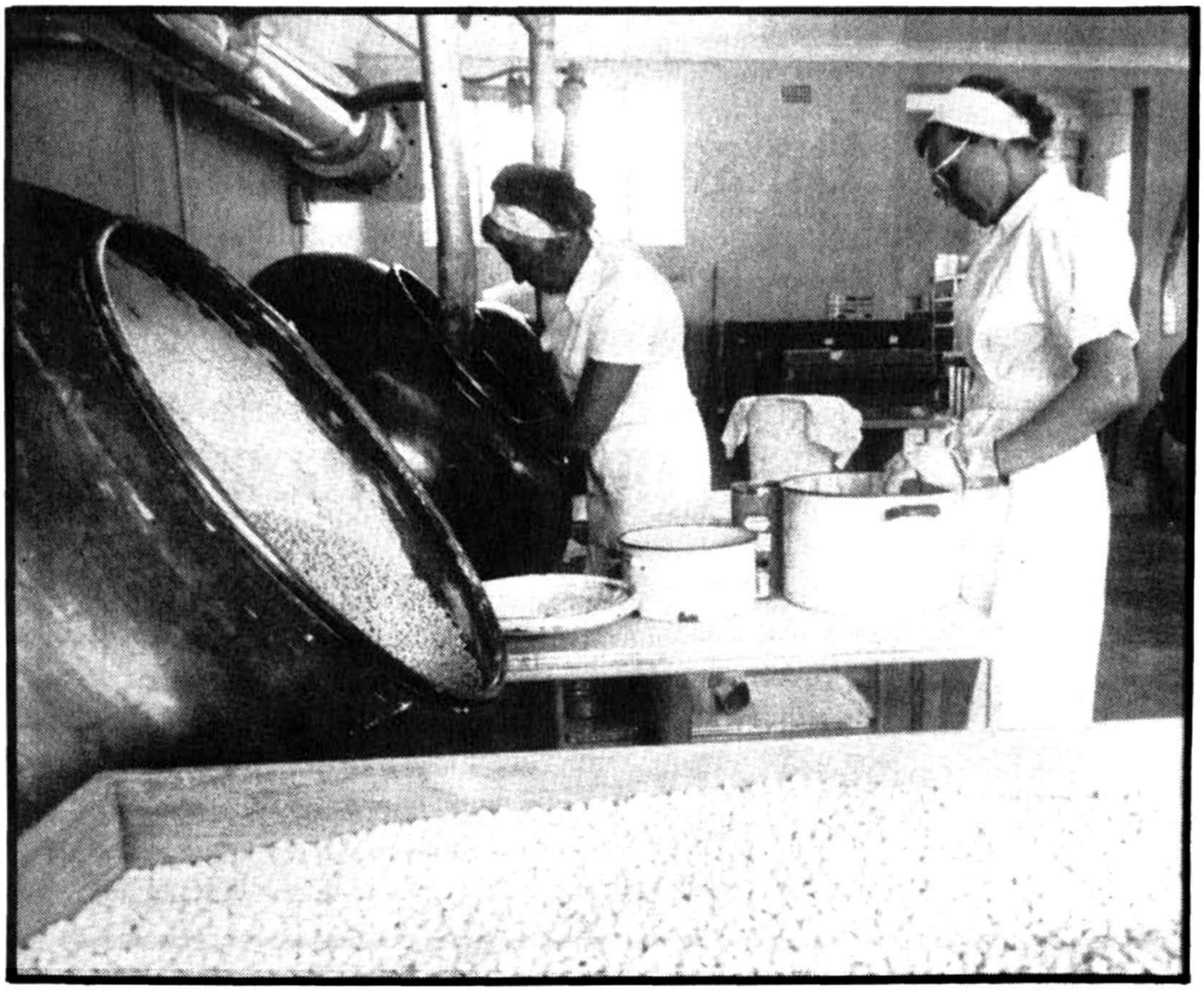
One area where the new emphasis on "self-help" is emerging very clearly is that of pharmacists and the pharmaceutical industry.

"Responsible self-medication"

One of the proposals for privatisation and cost-containment in the health sector relates to "responsible self-medication".

This proposed cost-containment measure elevates the pharmacist to the position of a dispensing doctor, according to the principle that "nobody should do a job that anybody with a lower qualification could do equally well". The Browne Commission of Inquiry into Health Services recommends that the public should be made aware of the pharmacists' services, and that pharmacists should be given more freedom to exercise their judgement. This recommendation was accepted by the government.

The Browne Commission relates primary health care to "responsible self-medication". To this end, the Commission recommends that medicines of Schedule 3 and 4 should be rescheduled to Schedules 1 and 2, giving the pharmacist a wider range of medicines that he/she can recommend for "responsible self-medication".



The Pharmaceutical Industry stands to gain from the programme of "responsible self-medication"

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SUMMER '85/86

South Af... non-pr... valuable hi...

Guidelines for using non-prescription medicines r...

Do read instructions carefully. Dosages differ for different age groups. If you're still in any doubt ask your pharmacist for advice.

The Report recommends that the public should be made aware of the pharmacist's services

Pharmaceutical industry and retail

Ever since these recommendations were published, there has been a noticeable shift in the advertising campaigns of certain drug manufacturers. More adverts are addressed directly to the consumer. The doctor is bypassed in the programme and practice of "responsible self-medication". The authority s/he would provide is represented by a reassuring "results guaranteed" quote in the advert itself. Drug adverts contain more information in the instructions and prescribed doses. But it is not only drug manufacturing companies that are stepping up and/or changing the content of their advertising and marketing campaigns. Pharmacies themselves are entering into the marketing business with slogans like: "Health indeed, advice in need, ... all the pharmacy you need"; "Your pharmacy knows best"; etc.

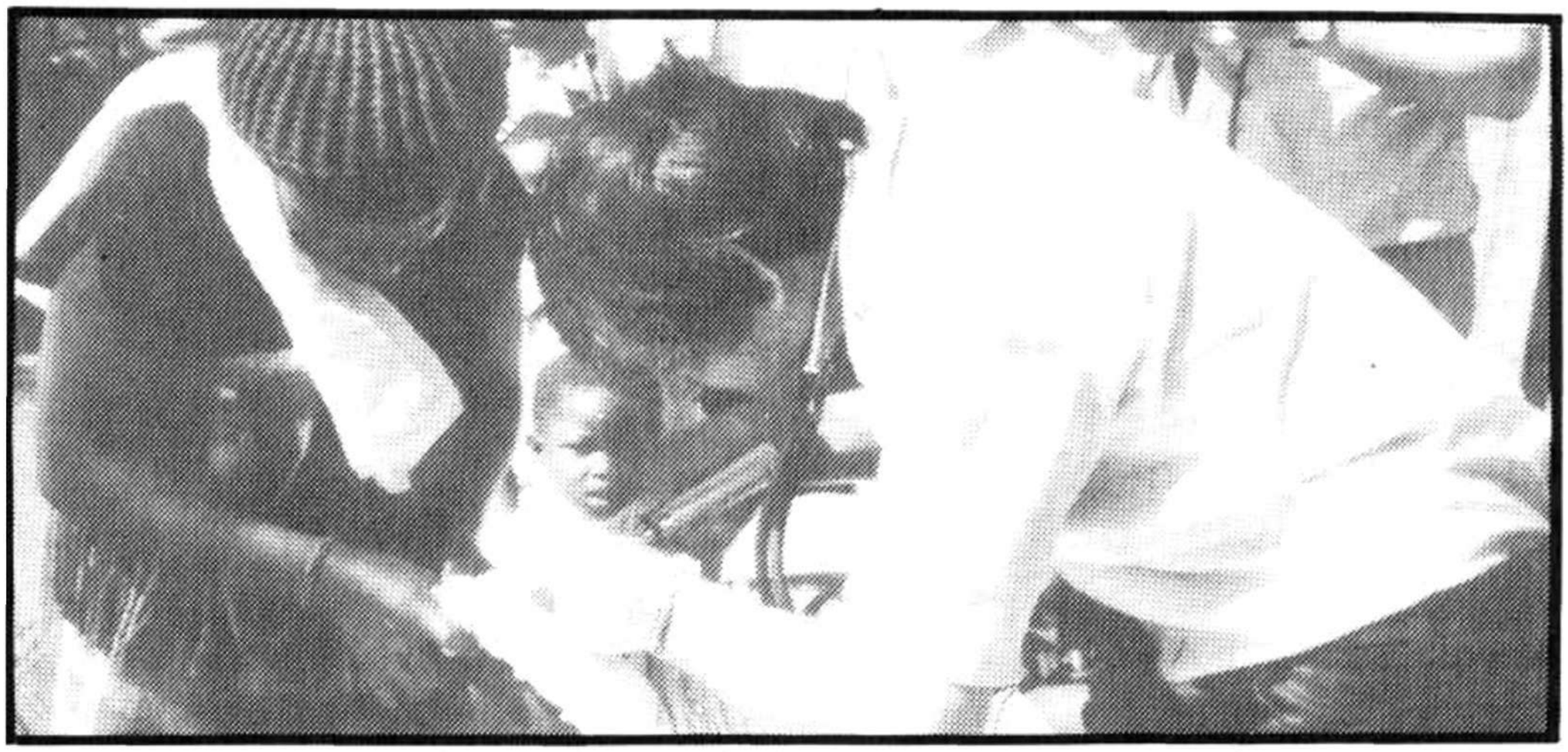
Although the pharmacist might give valuable advice in the case of some ailments, it is unrealistic and unethical to accord the pharmaceutical industry and retail such an important role in the development of health services on a national scale. The majority of people will not be able to afford medicines directly from the pharmacy. The pharmaceutical industry and retail have a vested interest in people's (ill) health, and cannot be expected to offer their advice and remedies without regard for the industry's financial returns.

A disproportionately large section in the Commission's Report is devoted to the pharmaceutical industry and retail trade. This indicates that the government allows health professionals with vested interests to play an important role in central decision- making on health matters.

Financing of health care: the individual, medical schemes and the state

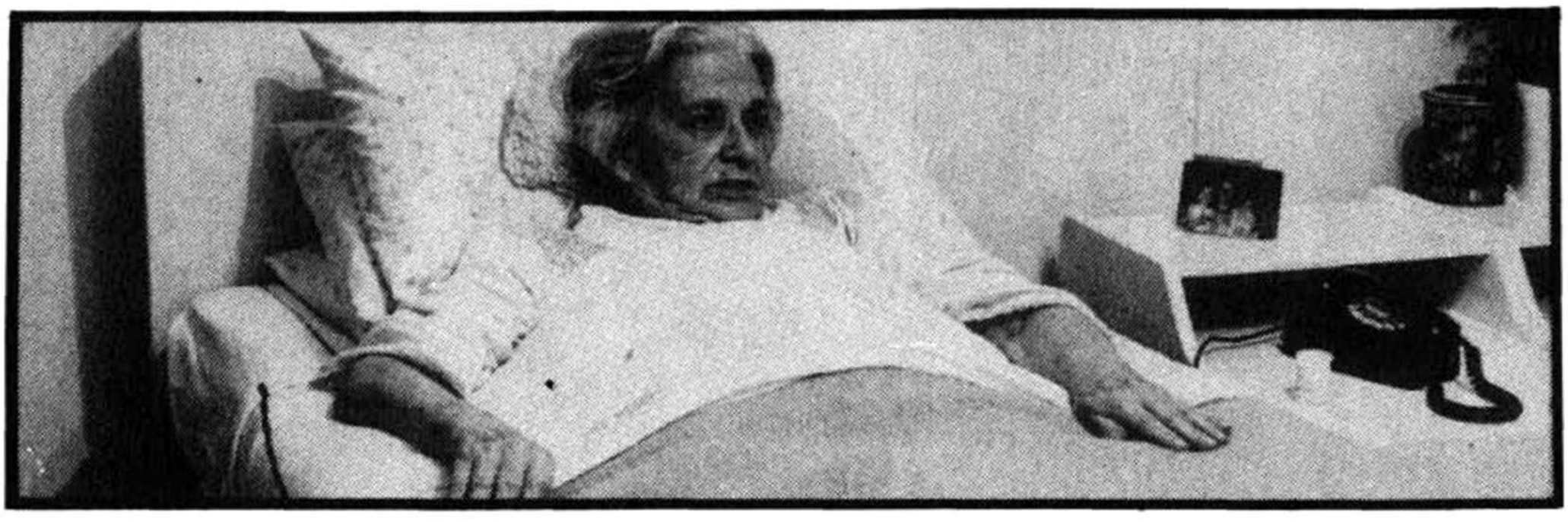
The premise that the individual is responsible for his/her own (ill) health implies, among other things, that the cost of health care should be borne by the individuals concerned. It has thus been suggested that medical aid packages available to individual subscribers should be restructured, allowing greater differentiation of benefits available to those contributing differential amounts. This means there will be different standards and qualities of health care: private care for those who can afford to pay the corresponding medical aid fees; state health care for the indigent, who will face extreme difficulties in proving that they cannot afford to pay; and "community health care" for those in remote areas without easy access to state health institutions. Formalising these three tiers of health care delivery institutionalises the class privileges that determine access to health care. State health officials have chosen this path, rather then that leading to a more healthy society.

Differential standards of health care: "State health care for the indigent"



"Community health care" for people in remote areas

Furthermore, as an ad-hoc committee on privatisation recommended, costs could be cut by making the patient pay for the first consultation each month, and by abolishing guaranteed payment of practitioners by medical aid societies. Another recommendation states that patients should be discouraged from overutilising health services. A spokesperson from Barlow Rand suggests, "we are all simply going to have to exercise more restraint over the number of visits we make to doctors and specialists, the treatments received, and the prescriptions dispensed". This suggestion seems inappropriate, as people do not choose to become sick.



Long-term patients - too expensive for private and state health systems

"Community health" - Third class health services

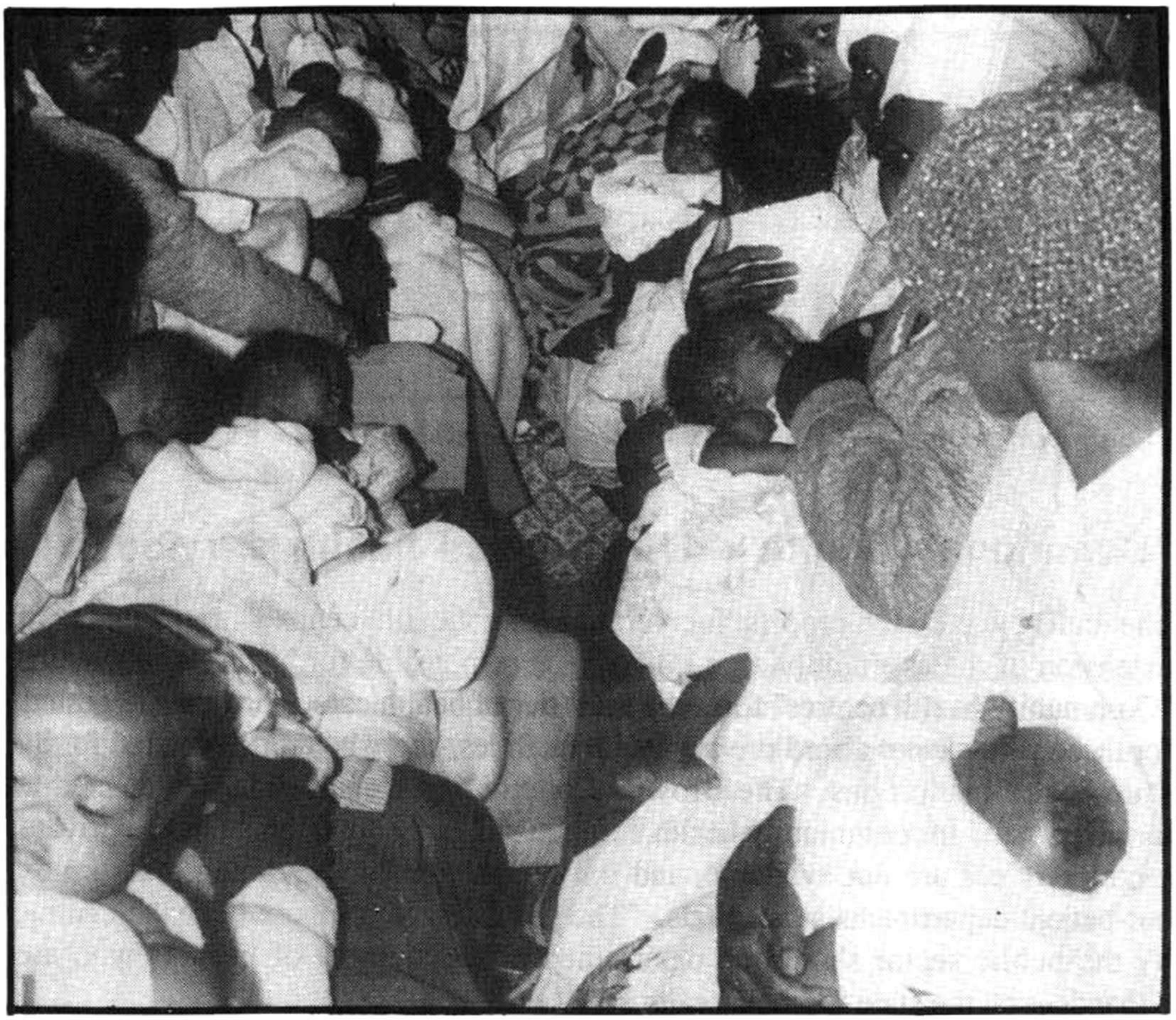
The call by official reports for "community health centres" represents an extension of the assumption that everyone is responsible for his/her own health. "Community health centres" form the third tier of health care. They are suggested for those who cannot afford private health facilities, and who are not catered for by state health institutions. The Browne Commission Report makes it clear that there is a need for community health care centres, but only in areas where private sector services are not available, and for the purpose of alleviating pressure on out-patient departments at hospitals. "The provision of community health centres by the public sector should be determined by the number of persons who are dependent on the state for their health services..."

The criterion of cost-effectiveness

In certain cases, "community health care" is seen to be more cost- effective than state or private health care. This is very clearly expressed in a statement by F.P. Retief, director-general of the Department of National Health and Population Development:

"The greater the use of high technology medicine in the private sector the more we have to give attention to cost. The big capital outlay on expensive equipment demands that it has to be used frequently to cover its cost ... The same principle holds for private hospitals where rapid turnover surgical patients are economically better propositions than long-term medical, psychiatric or paediatric patients."

It is therefore the principle of cost-effectiveness which underlies the authorities' and private sector's demand for community-based services. Longer-term patients do not make for profitable material and are therefore relegated to "community care". "Communities", however, are not equipped with the resources to care for the aged, the disabled, and people suffering from chronic illnesses.



Primary health care is advocated as a cheap service; yet this area is the most neglected in private and state health policies

Primary and preventive health care

The Browne Commission deplores that too much money and effort is being spent on expensive tertiary care, and too little on primary health care. This is supported by the government decision quoted in the Report: "...the solution to health problems does not lie with the provision of more hospital beds, but in the provision of adequate primary health care services." Public sector curative services take up 65% of the total health expenditure, with only 4,7% being allocated to preventive services. This imbalance is what both the Browne Commission and the National Health Policy Council address themselves to - not by making more resources available for community-based primary and preventive care, but by appealing to "people's own initiative" and "people's responsibility for their own health care". Such a crusade cannot replace the struggle for social justice. The equality of access to health services depends on this struggle.

It is recommended that the private sector should play a role in health education

Privatisation: The various interested parties

Privatisation of health care in South Africa is an attempt to shift state responsibilities for welfare and essential services to private enterprise. This move is politically and economically advantageous to the state and private enterprise.

Political aspects of privatisation

Privatisation in South Africa depoliticises health by shifting the emphasis on the racial inequalities within the state health care delivery system to a class-based system. The latter would cater for those who can pay high fees or who are fully covered by medical aid schemes.

Economic issues in privatisation

Economically, privatisation means that health care becomes a commodity. The profit motive is introduced into the previously state-provided sector. Introducing the element of profit as a motive for health care delivery raises certain issues, such as the following:

- what type of health care will be offered?
- where will these services be made available?
- to whom will these services be available?

Prognosis for privatised health care

If the concept of privatisation conforms to the principles of capitalist accumulation then the type of services provided will most likely depend on

A patient recuperating from an open chest operation at a private clinic

profitability and patients' ability to pay. In that case, these services will be predominantly urban-based, curative, sophisticated, and expensive. The private sector, despite its overtures for preventive and essential programmes, is unlikely to be prepared to provide low profit services.

Privatisation vs. the existing health care delivery system

The argument for privatisation is a convincing one in the light of the inadequacies of the existing health system in this country. It captures the attention of many people who, like the advocates of privatisation, are reluctant to see the health problem as an integral part of the political, social, and economic structures in South Africa. Yet the arguments for greater efficiency and cost containment, convincing as they might seem, are addressing the symptoms and not the causes of the health problems in this society.

Privatisation and free enterprise

The proponents of privatisation interpret the concept according to the interests of

Privatisation addresses symptoms, not causes of health problems

those groups advocating the "free market solution". These groups reason that health is a privelege, not a right and therefore can be distributed according to the supply and demand forces of the market.

The privatisation lobby

The private sector which advocates privatisation of health care consists of private health industry and services (eg private practitioners and hospitals, medical aids and pharmaceutical companies) and economists and business management consultants who support this sector.

These interest groups support privatisation on the basis that health care for profit will be more cost effective/efficient and more efficiently delivered than health care in the public sector. The market, it is claimed, introduces competition which in turn will promote a high standard of service. The profit motive will

ensure competent and appropriate costing strategies. To achieve these ends, health institutions, like any other business, will be run by business managers.

Some advocates of privatisation also promote the idea of "freedom of choice" in health, i.e. that patients will be able to shop around for the best care available, rather than being forced to utilise public services with all their inconveniences. This attitude seems to indicate the target population envisaged by the private health industry, for only the affluent or insured would be in a position to make this choice.

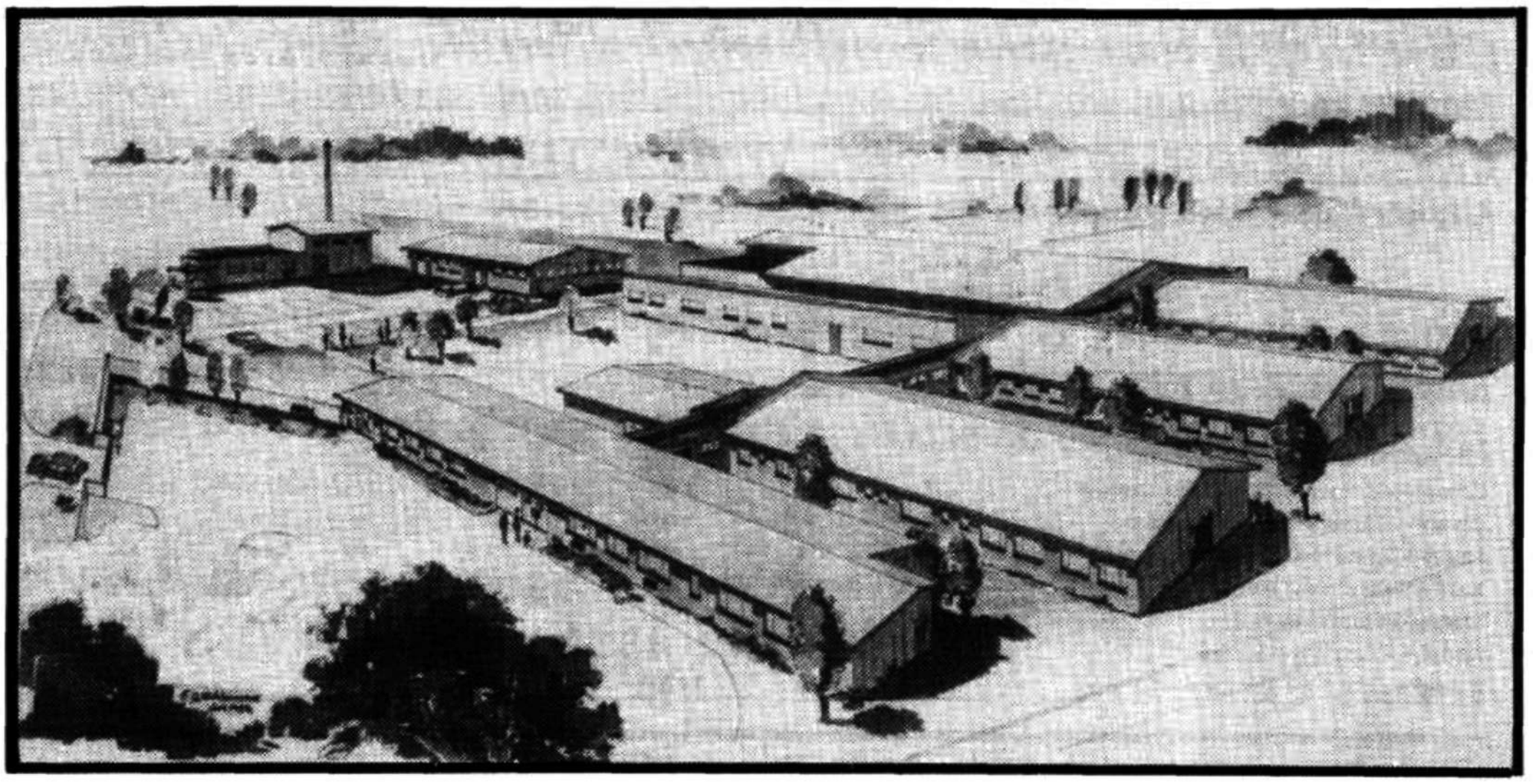
Proposals made by the privatisation lobby

Various strategies are proposed to "overcome" the limited access to private health care. The private sector is lobbying for deregulation and changes in legislation to "free" health services from the restraints of the present system. For example:

1. Changes are being sought to allow for the introduction of group health practice such as the health maintenance organisations (HMO's) of the USA. These HMO's are pre-paid membership schemes which offer services to members in accordance with a subscriber's level of contribution.

These pre-paid schemes are being promoted as an alternative to the fee-for-service model applied in South Africa. It is claimed that the fee-for-service practice, rather than encouraging cost containment, encourages over-utilisation of services by doctors and patients.

Health maintenance organisations, it is claimed, have inbuilt incentives for cost containment, e.g. patients are entitled to treatment only in accordance with pre-paid contributions; physicians are paid per enrollee not service; and physicians



An artist's impression of Lesedi Clinic

Subsidiary companies

	Nature of business*	Issued share capital		Effective Percentage holding		Book value of the company's interest Shares		Indebtedness	
		1986 R	1985 R	1986 %	1985 %	1986 R	1985 R	1986 R	1985 R
Subsidiaries incorporated in South Africa									
Afrox Limited	G	100	100	100	100	100	100	(1 085 781)	(713 154)
Afrox Finance Limited	F	60 000	60 000	100	100	60 000	60 000	(54 930 162)	(63 026 135)
Amalgamated Medical Services Limited	H	3 400 000	3 400 000	85	85	17 450 798	17 450 798	5 086 013	387 101
Ammed Medical Systems (Pty) Ltd	H	270	—	60		162	—	179 923	—
AOL Performance and Educational Services (Pty) Limited	I	200	200	100	100	200	200	(671 895)	236 340
Brenthurst Clinic (Pty) Limited	H	10 000	10 000	85	85	—	—	—	—
Brenthurst Dispensary (Pty) Limited	H	200	200	85	85	—		—	
Die Eugene Marais Gedenkhospitaal Apteek (Edms) Beperk	H	499	499	57	57	—	—	—	—
Dowson & Dobson Limited	E	1 000 000	1 000 000	100	100	3 674 208	3 674 208	(4 534 027)	(6 087 255)
Entabeni Hospital Limited	H	1 183 860	1 183 860	76	75	8 120 575	8 063 829	1 827 599	2 475 115
Florence Nightingale Nursing Home Limited	H	2 000	2 000	85	85	—		—	—
Glynnwood Nursing Home (Pty) Limited	H	1 000	—	85	—	790 892	—	(825 505)	—
Glynnwood Properties (Pty) Limited	H	6 000	—	85		533 963		—	
Harris Welding Equipment Co. (Pty) Limited	W	2	2	100	100	2	2	1 185 034	1 406 191
Home & Hospital Dispensaries (Pty) Limited	H	20 200	20 200	80	80	16 000	16 000	1 137 158	400 000
Industrial Research & Development (Pty) Limited	I	6 000	6 000	100	100	594 496	594 496	(441 177)	(379 797)
Industrial & Petroleum Valves Holdings (Pty) Limited	F	20 000	20 000	100	100	372 242	372 242	2 149 150	3 725 816
Industrial & Petroleum Valves International (Pty) Limited	F	100	100	100	100	—	—	—	—
Jomoru Investments (Pty) Limited	F	100	100	85	85	—	—	—	—
Kwest (Pietersburg) (Pty) Limited	F	1 000	1 000	100	100	46 973	46 973	3 963	44 429
Lady Dudley Nursing Home Limited	H	63 500	63 500	85	85	—		—	
Les Marais Verpleginrigtings (Edms) Beperk	H	499	499	55	55	—	—	—	—
Nasionale Sweisware (Edms) Beperk	W	2	2	100	100	2	2	(21	(2)
Nicoweld (Pty) Limited	W	1 200	1 200	75	75	21 446	21 446	53 910	(137 410)
Northern Dispensary Limited	H	200	200	85	85	—	—	—	—
Princess Dispensary (Pty) Limited	H	4	4	85	85	—	—	—	—
Randburg Nursing Home (Pty) Limited	H	100	100	44	44	—	—	—	—
Sapego Company Limited	I	10	10	85	85	—	—	—	—
The Princess Nursing Home Limited	H	10 785	10 785	85	85	—	—	—	—
United Medical Services Limited	H	37 000	37 000	85	85	—	—	—	—
Welding Electrode Manufacturing Co. (Pty) Limited	W	60 000	60 000	100	100	563 140	563 140	(4 164 635)	(2 752 679)
Subsidiary incorporated in South West Africa									
South West African Oxygen (Pty) Limited	G	280 000	280 000	100	100	280 000	280 000	1 349 610	1 487 764
Subsidiary incorporated in Malawi									
Industrial Gases Limited	G	K2 133 334	K1 866 667	75	75	318 054	318 054	—	
Subsidiary incorporated in Swaziland									
Swazi Oxygen (Pty) Limited	G	E8	E8	100	100	8	8	782 578	659 497
						32 843 261	31 461 498	(52 898 246)	(62 274 179)
Non-trading companies						1 345 554	1 345 554	(887 352)	(858 321)
						34 188 815	32 807 052	(53 785 598)	(63 132 500)

Unlisted associated companies

	Nature of business*	Issued share capital		Effective Percentage holding		Book value Group		Company	
		1986 R	1985 R	1986 %	1985 %	1986 R	1985 R	1986 R	1985 R
Bendor (Pty) Limited	H	4 000		20	—	32 245	—	32 245	—
City Park Hospital (Pty) Limited	H	—	4 000	—	50	—	2 000	—	2 000
City Park Medical Centre (Pty) Limited	H	—	4 000	—	50	—	2 000	—	2 000
Glynnwood Nursing Home (Pty) Limited	H	—	1 000	—	42,5	—	266 255	—	266 255
Glynnwood Properties (Pty) Limited	H	—	6 000	—	42,5	—	58 600	—	58 600
Hiway Medical Holdings (Pty) Limited	H	951	951	34	34	400	400	150	150
Les Gaz Industrials Limited	G	RS 13 056 960	RS 13 056 960	34	34	85 401	85 401	85 401	85 401
Magnolia Clinics Limited	H	1 000	1 000	32	32	814 016	814 016	814 016	814 016
Nedpark Clinic (Pty) Limited	H	100	100	32	32	32	32	32	32
Rainspray Holdings (Pty) Limited	F	19 200	19 200	50	50	—	—	—	—
						932 094	1 228 704	931 844	1 228 454

A large number of private hospitals are AFROX business ventures

Here's THE plan to help you get the money you'll need if you go to hospital anywhere in the world for

HEART ATTACK, CANCER, STROKE SURGERY, or any other serious illness.

PLUS...an extra R10 000 paid in the event of accidental death.

GUARANTEE OF ACCEPTANCE
You cannot be refused this hospital insurance protection if you are between 18 and 64 years of age. No medical examination is required, and no health questions asked. But you must reply **before 26th February 1987.**

Ask yourself now before it is too late...when you're in hospital, who will pay for those costs not paid by medical aid?

Even if you have medical aid, and you go to a state hospital, you will have to pay a portion of the costs. The amount will vary according to your income, but you will still have to pay.

Many people want the more individualised treatment and care provided by private clinics. But to get them you must pay an even more significant amount of the costs for:
- the portion of your daily room cost not paid by medical aid
- laboratory fees and tests
- fees of doctors and surgeons
- drugs, anaesthesia, therapies, etc.

Whether you go to a state hospital or a private clinic, there providing for the expenses that arise when there's no one left at home to take care of your household.

Cash Benefits paid directly to you

Your cash benefits are paid directly to you – not to a doctor or a hospital.

You are the best judge of what your needs and extra expenses are, and The Hospital Insurance Plan allows you to use your cash benefits as you see fit.

Also, these cash benefits are paid in addition to any benefits you may receive from any other insurance...regardless of the actual amount of your hospital bill! When you make a claim, no questions are asked about any other insurance.

You pay only R2.00 for your first month's cover...so the more cover you choose, the more money you save

	Monthly* Premiums for	Age at last birthday 18-39	40-49	50-59	60-64
PLAN A pays you R90.00 a day	Individual only	19.15	28.45	39.77	44.95
R630.00 a week,	Individual and spouse**	38.85	54.20	75.75	83.65
R2 790.00 a month up to R32 850.00 in cash for each covered hospital stay	Individual and children***	46.90	68.20	47.90	50.35
	Entire family	49.20	63.95	83.55	90.05
PLAN B pays you R60.00 a day	Individual only	10.45	19.30	26.80	29.65

One suggested measure of cost-containment is separate catastrophic cover

are subject to peer review. All these suggestions are cited as solutions to "overtreatment" of patients.

2. Changes in the medical aid structures are suggested as part of the cost containment strategy. The call is for flexibility of schemes and pre-paid health insurance. Both of these may offer packages to suit the patient's predicted requirements and both offer levels of entitlement in accordance with contributions. The lower the premium the more basic the care, the higher the investment the greater the care available.

Incentives such as no claim bonuses, co-payment by patients and separate catastrophic cover are also being suggested as methods of cost containment in health care delivery. All of these proposals are based on the assumption that the patient can predict their disease profile.

Private doctors, medical aids, and the pharmaceutical industry

A local financial newspaper reported in November 1985, that medical aid tariffs had increased 500% since 1975.

The cost of private health care in South Africa is very high. The causes of this cost escalation are being debated by the private health industry, each sector blaming the other for this state of affairs.

Private practitioners are "over-servicing", patients are "over- using", pharmaceutical companies are "over-marketing", private clinics and medical aids are "over-charging".

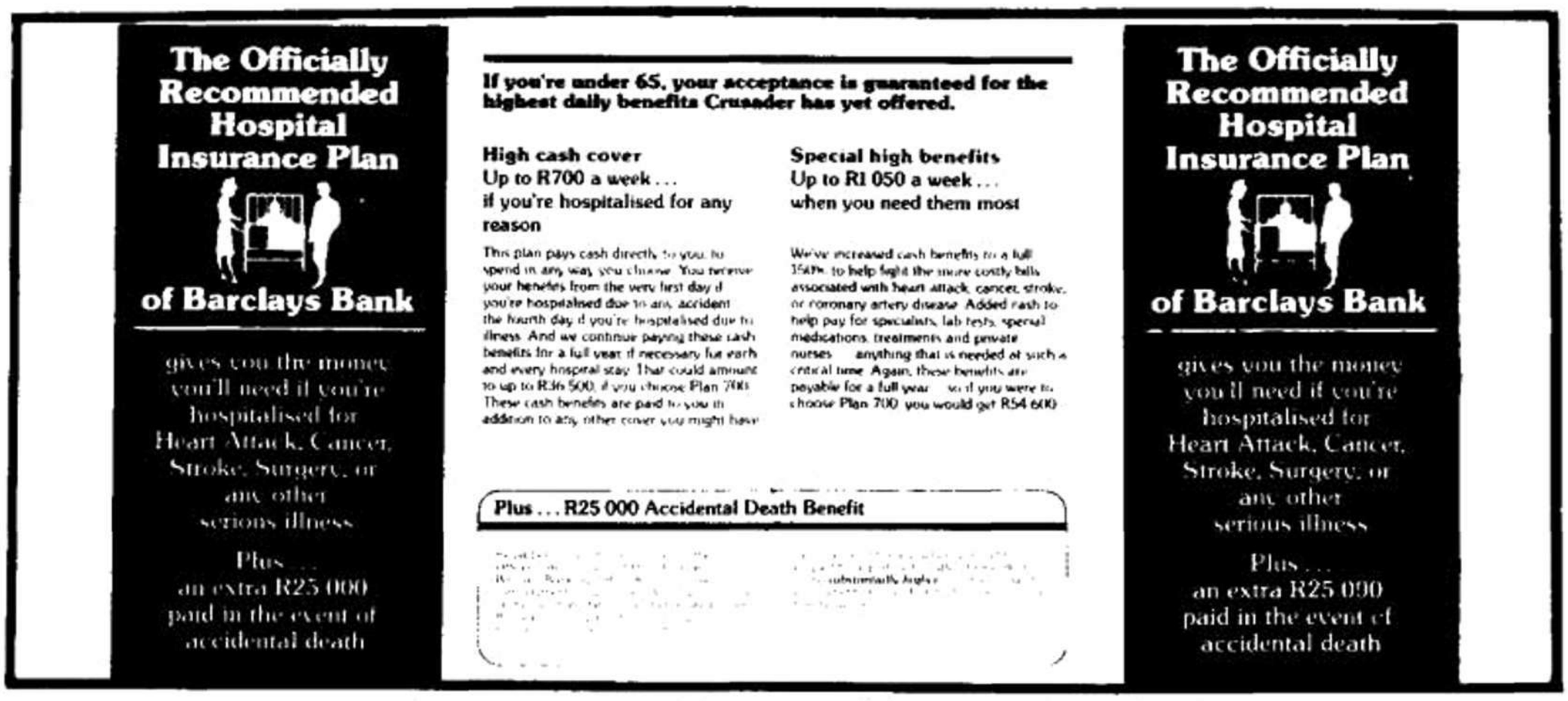
Medical schemes, in their search for cost containment measures, are lobbying for legislative changes which will allow for flexibility of medical cover and the removal of guaranteed payments. Medical aids blame doctors' tariffs, over-usage of services and drugs by doctors and patients, and the high cost of medication for the increases in medical aid contributions.

Doctors, in turn, lay much of the blame for their problems on the medical aid system. They are reluctant to forego guaranteed payment as a means of containing costs. Instead they are suggesting alternative methods of cost containment, e.g. responsible self medication, co-payment by patients and subsidised care for those who cannot afford expensive care.

This merry-go-round fails to address the fundamental causes of and solutions to health and ill-health.

Conclusion

All of these debates and "solutions" reflect the different interests of the various sectors of the private health industry. The privatisation platform is debating health care at the level of symptoms and not the causes of health care deficiency in South Africa. The primary aim of the interested parties is cost and efficiency. This is in stark contrast to the fact that the health care deficiency is caused by disproportionate distribution of the human and material resources of health.



Medical aids are primarily available to salaried, skilled, white employees

TOMORROW BEGINS AT WITS TODAY

LOOKING FOR A JOB IN PRIMARY HEALTH CARE?

The Health Services Development Unit has two vacant doctor posts.

We need doctors to help us train Primary Health Care Nurses (PHCNs). We run a year-long course at Tintswalo Hospital (near Acornhoek and the Kruger National Park), training PHCNs from the north-eastern Transvaal region. The course aims to produce caring PHCNs who can diagnose and treat common conditions, manage clinics, and who understand the social aspects of health and disease.

Other work can include clinical sessions in the hospital, research and contributing to our other projects: a women's village development programme; a continuing learning programme for PHCNs; preparing learning materials for PHCNs; training teachers of PHCNs; a proposed village health worker training programme; co-ordinating final year medical students on their rural block.

The successful applicant must be prepared to work at Tintswalo Hospital. The starting time for the job is negotiable, but we would like the applicant to begin work as soon as possible.

What skills do you require?

The following skills are desirable, but most of the skills can also be learned on the job: Adult education; Primary health care: Clinical care. Applicants should be prepared to work as part of a team of health workers.

Conditions of employment

Housing is provided at a nominal rent and salaries are negotiable according to experience and qualifications. Opportunities also exist for own professional self-development and for visiting other programmes, conferences, seminars, etc.

What is the Health Services Development Unit?

We are part of the Department of Community Health at the University of the Witwatersrand Medical School with a mandate to initiate innovative and experimental primary health care projects.

For further information, contact Cedric de Beer at (011) 647-2269 or 647-2051.

Submit applications with a curriculum vitae and the names and addresses of two referees to Cedric de Beer, Department of Community Health, Medical School, 7 York Road, Parktown, Johannesburg 2193.

UNIVERSITY OF THE WITWATERSRAND

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PERSONA 500619

Deregulation of small businesses: Who pays the social costs?

"Deregulation" is generally understood to mean the development of the private sector, unfettered by the state, and its law-enforcement machinery. It is a concept used by many official reports in connection with the programme of privatisation.

"Deregulation" has become topical with the abolishion of certain standards pertaining to the manufacture of medicines, and with the relaxation of the Medical Schemes Act, and social security laws covering workers.

It is in the fields of working conditions, occupational health and safety, and social security that deregulation has the most far-reaching consequences. This article attempts to explain the political origins, objectives, proposals and consequences of the "Report of the Committee of Economic Affairs on a Strategy for Small Business Development and for Deregulation". This Report is the precursor of the Temporary Removal of Restrictions on Economic Activities Act, no. 87 of 1986.

The 1983 Constitution and deregulation

The 1983 constitution, which provides for a tri-cameral parliament, cites as national goals (among others): "to respect, to further and to protect the self-determination of population groups and peoples, and to further private initiative and effective competition."

The state president requested the President's Council to advise him on ways and means of putting these aims into practice. The request was then referred to the Committee of Economic Affairs, which in 1985 published its "Report on a

Strategy for Small Business Development and for Deregulation". This Report served as the basis for the Removal of Restrictions on Economic Activities Act no. 87 of 1986, which empowers the state president to exempt certain businesses from certain minimum requirements. The specific regulations concerning small businesses' exemption will be issued by proclamation - probably after the elections in May.

Objectives of the Report

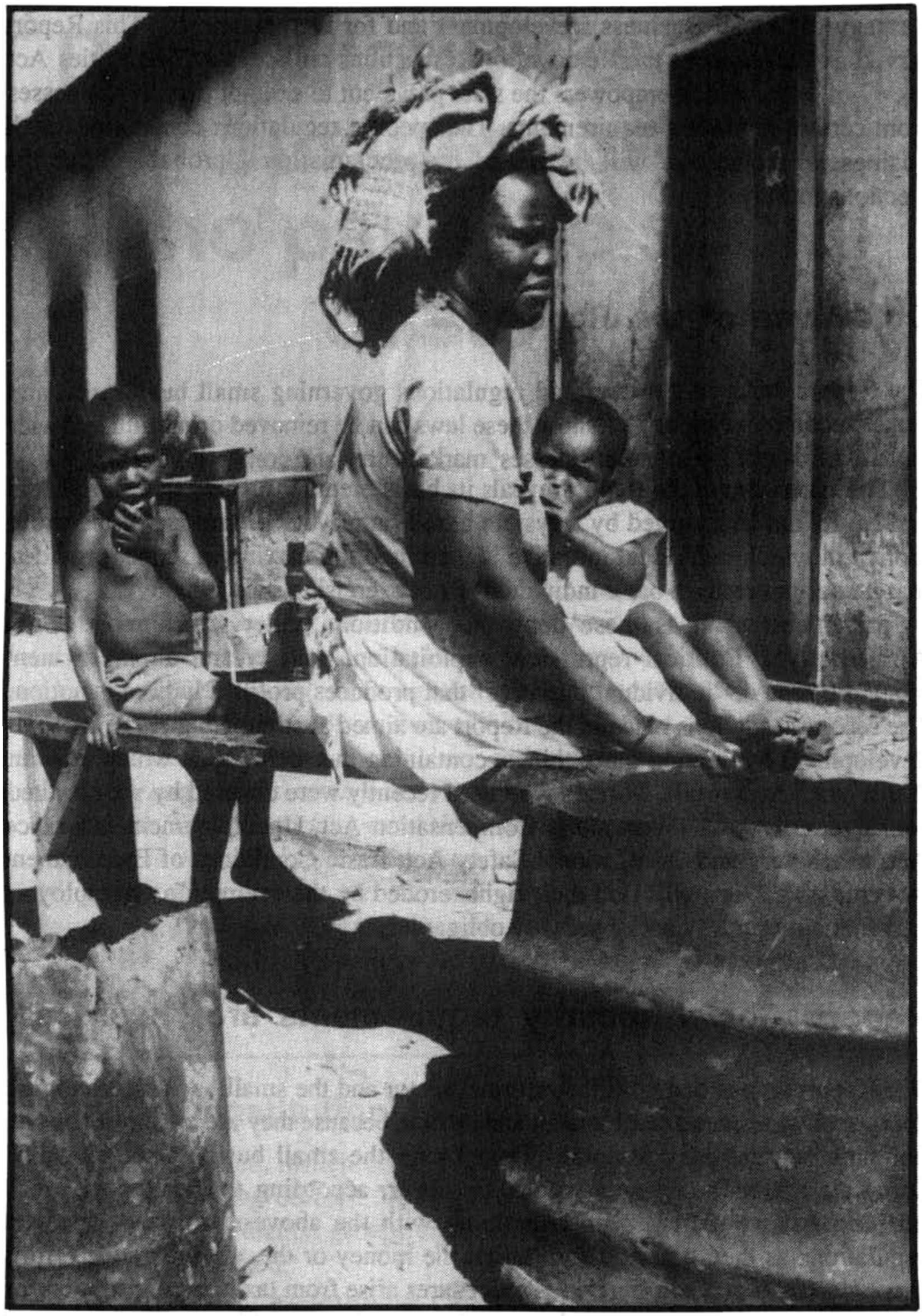
The Report looks at the laws and regulations governing small businesses, and makes recommendations as to how these laws can be removed or minimised, with the aim of increasing small businesses' market entry and competitiveness.

The stated aim of the Report reveals its basic premise, namely that "...freedom and equity are best served by a system based on private enterprise or the profit motive in which individual initiative is permitted the maximum scope, provided that it does not restrain other individuals from exercising such initiative".

Statements such as these deny the conditions under which most South Africans live. Political repression, exploitation, poverty and unemployment make the kind of "individual initiative" that produces profits a ludicrous notion. The recommendations made in the Report are aimed at stimulating small business development by, among other things, containing the social costs which arise in that sector. As a result, workers who until recently were covered by very limited social security laws (Workmen's Compensation Act, Unemployment Insurance Act; Machinery and Occupational Safety Act; Basic Conditions of Employment Act and Wage Act) will find their rights eroded by the exemption of employers from certain statutory social security obligations.

Report: Social security requirements are "luxuries"

The Report argues that both the informal sector and the small business sector are sources of widespread employment and income because they are labour- intensive, competitive, and easy to enter. Developing the small business sector would stimulate the economy as a whole. However, according to the Report, small businesses have difficulty in complying with the above-mentioned laws and regulations as they cannot afford either the money or the administrative efforts involved. Costs and administrative procedures arise from taxation; registration for GST; compensation and unemployment benefits for all staff members; satisfying factories, health and safety and fire protection inspectors; registration of black



Widespread poverty and unemployment contradict the notion of "individual initiative" stressed by the Report

Will the informal sector gain anything from deregulation?

staff members; Industrial Council regulations; minimum wage stipulations; returns to the Department of Statistics; licensing requirements; etc.

The Report comments on these requirements:

"Many of these rules and regulations that seek to prevent social costs ... can be regarded as luxuries that only wealthy societies can afford. If they were applied to the informal sector the cost of economic activity would increase to a level that could not be borne by informal sector entrepreneurs."

Proposals of the Report

The Report proposes that the social costs of small businesses should be contained by a "flexible approach in applying standards". This would make it easier to comply with laws and regulations, and so facilitate the with the setting up of a small business. According to the Report, there should be minimum entry standards, and tighter controls should be imposed only *after* the business has been established.

Political aspects of the Report

The main thrust of the Report appears to be limiting the costs of small businesses, in order to increase and strengthen small business operations, with the aim of promoting overall economic growth. If, however, we look at the Report more closely, the *political* motivation of the recommendations become apparent. In commissioning the investigation, the state president requested that special attention should be given to *"the development function rather than pure*

financing". One of the objectives listed by the Report is "increasing the participation of economically less developed communities in the economy and improving their perceptions of the merits of the free market system".

Definitions of "small business"

The recommendations of the Committee might well result in more people finding more ways and means of surviving (for instance through enterprises like pirate taxis, shebeens, hawking, backyard mechanics and other forms of small trade and services). What is defined as "small business", however, is so vague that the deregulation which the Report proposes could serve as a model for the economy as a whole. In that case, small businesses in the informal sector would be immediately thwarted.

The Committee makes it clear that it gives first priority to the deregulation of small businesses proper. But by quoting examples of deregulation in the US, the Committee implies that its recommendations go beyond the interests of small business operations. The examples of deregulation in the US cover enterprises in the fields of transportation, banking, energy, and telecommunications.

The definition of "small business" to which the Report applies its deregulation recommendations is equally wide: "This definition covers a wide spectrum of small, independent undertakings ranging from highly sophisticated, modern concerns to unsophisticated concerns, often a single person, making a precarious existence in the informal sector, peripheral to the modern market economy." The Report lists a number of sectors into which its definition of "small businesses" might fall:

- Retail
- Private transport
- Manufacturing
- Construction
- Wholesale trade.

Though individual enterprises within these sectors may be "small" (using turnover and the number of employees as criteria), the overall number of employees who might be affected by the lowering of standards and social security provisions is substantial. Small businesses and informal sector operations are notorious for paying low wages, and any exemption from the Wage Act and other laws can only further lower the workers' standard of living and health.

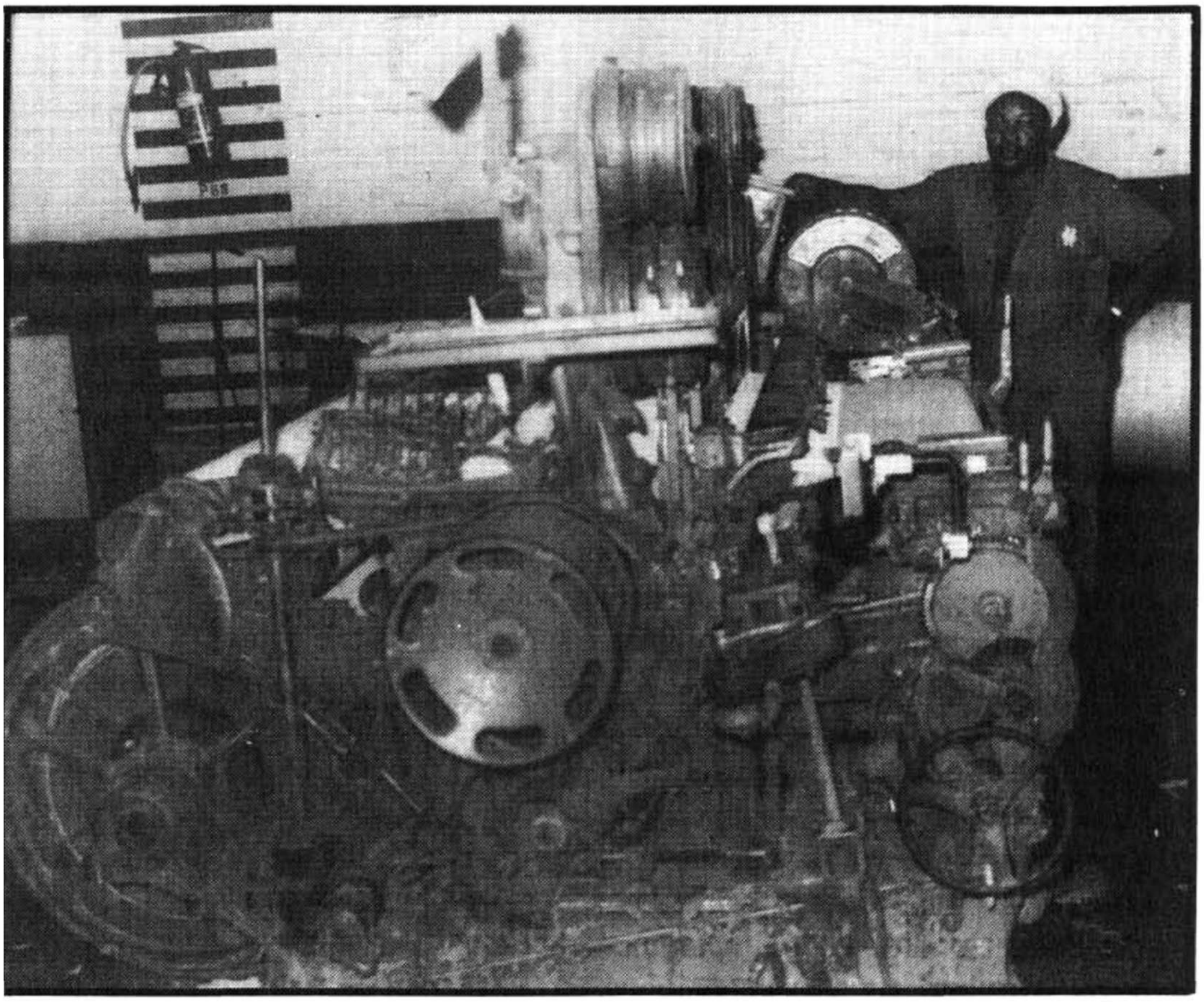
Workers stand to lose what little protection they have in the law

- the Wage Act of 1957, which obliges an employer to pay a minimum wage; to keep a daily attendance register, and a prescribed wage register for every employee
- the Unemployment Insurance Act of 1966, which obliges employers and employees to contribute to the Unemployment Insurance Fund. Many small business employers are not registered, and their employees are therefore not covered under the Act. The Committee supports such exemption.
- the Workmen's Compensation Act of 1941, whereby every employer employing one or more persons has to register with the accident fund and pay accident insurance premiums. The Committee applies a cost-benefit analysis to this form of insurance: it recommends that "Consideration should be given to the question of whether the collection of contributions to the accident fund is a cost effective exercise for the Fund in respect of small business employers".
- the Basic Conditions of Employment Act of 1983, which deals with working hours, overtime pay, leave conditions, termination of service procedures, annual and sick leave conditions, and service contracts. The Committee recommends

the exemption of small businesses from those requirements which are difficult to meet, especially record-keeping; the necessity for keeping records is implied in this Act.

- the Machinery and Occupational Safety Act of 1983. This Act exempts industries employing fewer than 7 people from certain provisions relating to health and welfare. With regard to this Act, the Committee recommends that these exemptions should be expanded.

All these laws and regulations were originally formulated to guard minimum health and safety standards for workers. Yet the Committee appears to regard these laws as dispensable. These laws represent one of the few instances where the state enters into capital-labour relations, though the state does very little to enforce the laws and regulations. So deregulation will not significantly help the informal sector but it will significantly erode the few safeguards for workers in "small businesses" in the formal sector of the economy.



Noisy machinery in a textile plant: Will workers be entitled to safe machinery and compensation?

The Health Act, among other things, lays down standards for the handling of foodstuffs

The Health Act

It seems the central state is happy to allow costs arising from inadequate or dangerous working conditions, to be transferred to individual workers and employers. This is particularly clear from the recommendations the Committee makes with regard to "minimum standards" and "public health".

It is only when it comes to potential threats to "public health", rather than the health of workers, that the central government wishes to continue to enforce minimum standards: The Committee reminds the authorities that they "... cannot altogether ignore social costs since the cost to the community may eventually turn out to be too high."

The Committee therefore recommends the maintenace of minimum health standards "to protect society against disease" - meaning infectious diseases which are not limited to the workforce.

It is thus no coincidence that of all acts providing for health and social security, only the Health Act of 1977 has been rigidly enforced.

The Health Act will remain in force to safeguard "public health"

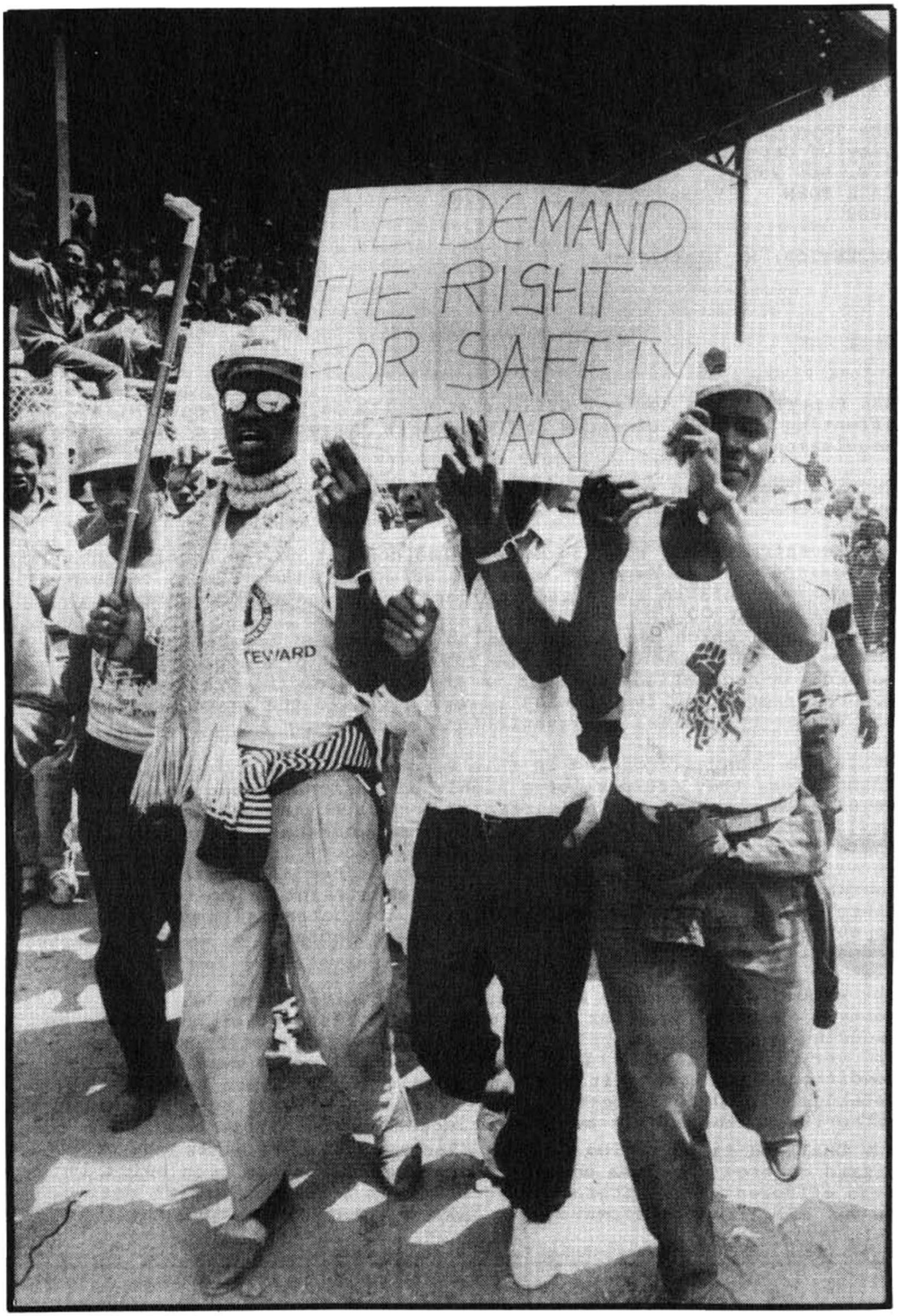
This Act lays down standards for premises, buildings, equipment used for handling foodstuffs, sewerage and draining systems, washing and toilet facilities, tiling of walls and floors, lighting and floor space, storage and transport of foodstuffs, etc. Of all the acts dealing with health and social security, the Health Act is the only one which effectively prohibits the operation of non-complying businesses. The concern here is to prevent the spread of disease to the wider community rather than protecting the health of workers themselves.

Opposition

Both big business and the union movement have expressed opposition to the proposals of the Report. Big businesses fear that they will be undercut by exempted businesses, while union representatives foresee that workers will lose the little protection they have in unorganised sectors and areas. The unions also fear that employers who feel threatened by organised workers could shift production away from unionised areas into areas where exemptions might apply.

Conclusion

Several of the laws laying down standards for health and safety at work, and for social security of workers, are characterised by exclusions rather than inclusions. They have been criticised as inadequate because they are not sufficiently comprehensive: the benefits themselves are inadequate, there is not enough protection for workers against unfair labour practices, and workers experience great difficulties in claiming benefits. If the regulations to be proclaimed soon incorporate the recommendations of the Committee, workers will lose even these few benefits and rights.



Unions oppose deregulation, as it will cut down on workers' rights

29 January 1987

The Town Clerk
City of Cape Town
P.O. Box 298
CAPE TOWN
8000

ATTENTION: Mr Blackshaw

Dear Sir

RE: Report of the Medical Officer of Health on Health Legislation affecting Business Licences and Proposals thereon with a view to De-Regulation

We have been asked by the Transport and General Workers' Union to submit comment on the above Report.

Time constraints do not allow detailed comment on the specific changes recommended in the Report. However, we would like to make certain general comments on the trends evident in these recommendations.

This Report, which deals with Health By-laws and Regulations administered by the City of Cape Town, is part of a general move towards de-regulation, obvious in the thrust of the President's Council report and the special powers given to the State President by the Temporary Removal of Restrictions on Economic Activities Bill.

While the changes proposed in this Report may seem trivial in themselves, they are part of a highly significant trend towards de-regulation which is being aggressively pursued and has important implications for the health and safety of workers. It is notable that there is no indication of concern on this score in the Report. The potential impact of de-regulation on public health (eg through contaminated foodstuffs) is cited as a constraint on de-regulation but there is no equivalent consideration of the potential impact of such measures on the health of workers in the affected industries/undertakings.

The Report recommends a shift from an 'ex ante' to an 'ex post' control approach in order to ease the establishment of businesses by reducing the initial capital outlay involved in meeting standards. At the very least, this will delay the introduction of decent working conditions. At worst, it may mean such conditions are never established. Unless there is very close supervision by the local authorities, there will be little incentive to improve conditions once the business is operating. It is also short-sighted: dealing with hazard control problems once a process/workplace has been built is less efficient than incorporating controls into the initial design. It may also be more expensive to make changes afterwards, a further

South Africa has minimal legislative protections for workers' health and safety. This is obvious in any comparison with legislation in other industrialised countries. The Commission of Enquiry on Occupational Health (Erasmus Commission) revealed appalling conditions in a wide range of industries. After a very long delay, the Machinery and Occupational Safety Act was passed in 1983. The Act shows evidence of the concern expressed in Wiehahn Commission recommendations that South African labour law and practice should be in line with international standards. While this Act allows employers much control over health and safety matters, it also endows workers with important new rights and legal protection. The current moves towards de-regulation and downgrading of standards are in direct contradiction to the structures and procedures of MOSA.

It is unrealistic to regard the de-regulation process as reversible in the event of economic recovery. The suspension of protections is likely to be permanent. De-regulation represents an erosion of the already limited rights of workers and will have particularly devastating effects on the most vulnerable groups of workers, for example those in small and isolated workplaces and those not organised into trade unions. The uncertainty of workers' position is exacerbated by the piecemeal way in which protections would be dismantled via exemptions and deregulation, and the extended discretionary powers of the enforcing authorities.

The recommendations contained in this Report, while minor in certain respects, indicate a shift in attitudes from the establishment and enforcement of general standards to a piecemeal application and progressive weakening of such standards as exist. In such a climate, it is likely that employers will seek to escape the 'inhibitory' effects of further sections of legislation. With the assurance that 'any deregulation proposals will be viewed favourably by the State' they are given every encouragement to apply for abolition of, or exemption from, the few standards that remain.

All these factors give rise, we believe, to a situation with potentially serious implications for the health and welfare of workers. In the longer term, one would hope that the Council and other responsible authorities would seek ways to extend and secure the minimal rights of workers with regard to workplace health and safety. In the short term, we would urge that the City Council at least review its recommendations on de-regulation with a view to assuring that these rights are not further undermined.

Yours faithfully

Judith Cornell

for the **INDUSTRIAL HEALTH RESEARCH GROUP**

Occupational Health Services: Whose responsibility?

Privatisation of occupational health services raises different issues from those arising from privatisation of health services generally. In occupational health, this article argues, services should be provided by employers, with the state legislating and enforcing certain standards with regard to working conditions and services. It is exactly this role that the state is eager to relinquish. This article looks at existing and alternative occupational health service functions.

Through work we should be able to contribute to the well-being of ourselves and our community. Work should also promote good health, but if it does not do this, it should at least leave us unharmed and able to lead a productive life.

However, work often does the opposite. Poor pay and boring repetitive tasks in a dangerous and demanding workplace cause stress and physical harm. The older menaces of unsafe machinery, dangerous workplaces (for example underground mines), asbestos and lead are still present; and added to these are the newer chemicals which cause cancer or affect our ability to produce healthy offspring or the ability of our bodies to fight disease.

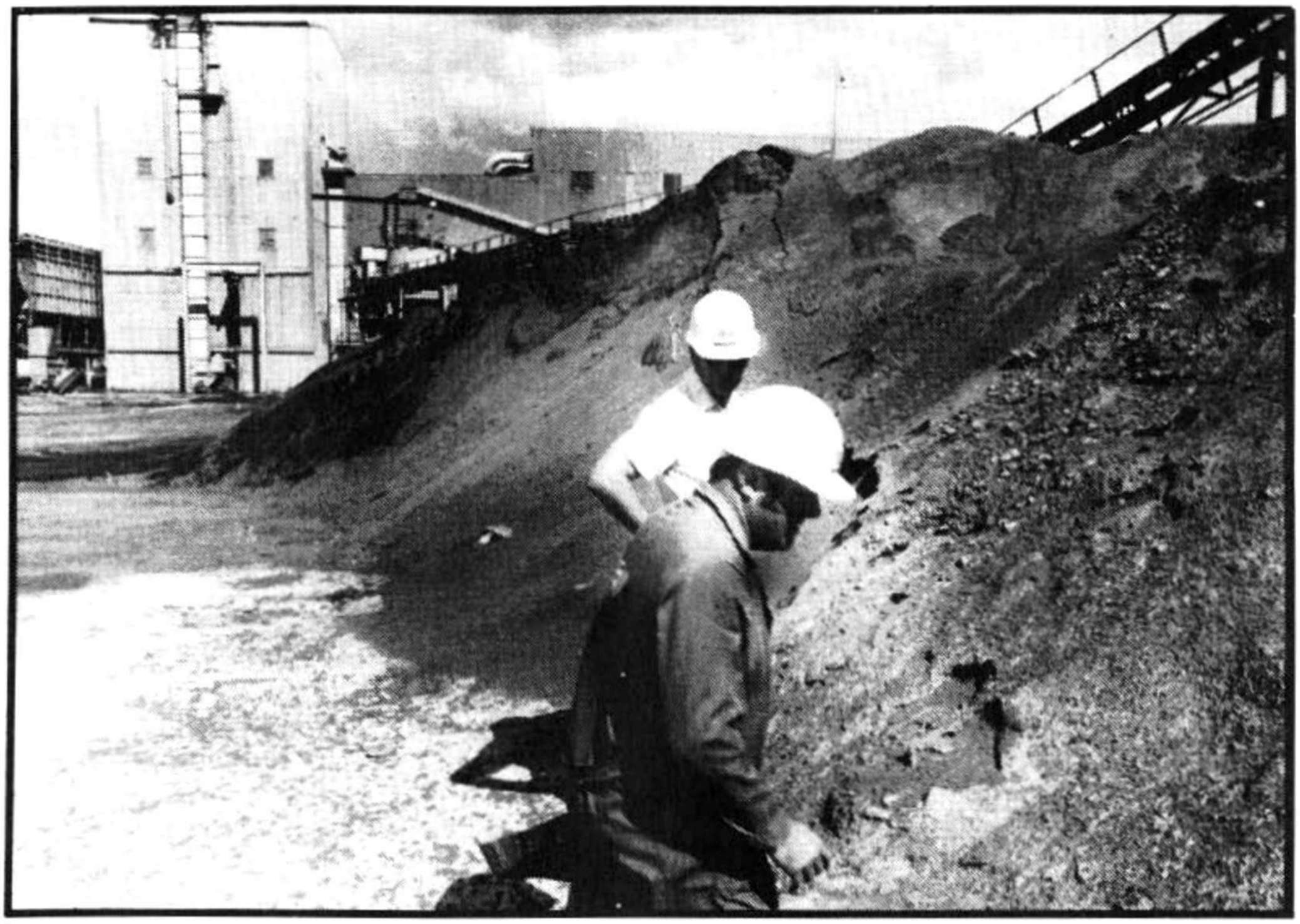
Workers are not the only part of society affected by these hazards. Family life is disrupted when a worker is suffering from stress or unable to find work because of poor health. Workers can carry dangerous material home on their workclothes. Waste products from factories pollute the environment and cause sickness in communities around factories. Occupational Health Services (O.H.S.'s), to protect us from the hazards produced in workplaces, are therfore urgently needed.

Workplace hazards and stress do not only affect the worker; these factors are carried further to the family and community life

The functions of Occupational Health Services

The World Health Organisation (WHO) states that an occupational health service should work for the following:

- The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations.
- The prevention among workers of departures from health caused by their working conditions.
- The protection of workers in their employment from risks resulting from factors adverse to health.
- The placing and maintenance of the worker in an occupational environment adapted to his/her physiological and phsychological condition.



There is a need for regulations and services which protect the environment from dangerous substances

An occupational health service may also act to protect society by ensuring that dangerous chemicals are not released into rivers or the air and ensuring that dangerous products are not sold to the public. Health services located at workplaces could be extended to provide for those living in the vicinity of the workplace. In third world countries many people have no access to health care. This means communities around factories or mines may be starved of health care while health services nearby are locked behind factory gates.

Who should control the Occupational Health Service?

(For simplicity all those who share the profit produced from a workplace, e.g. the owners and shareholders, are called management.)

Management

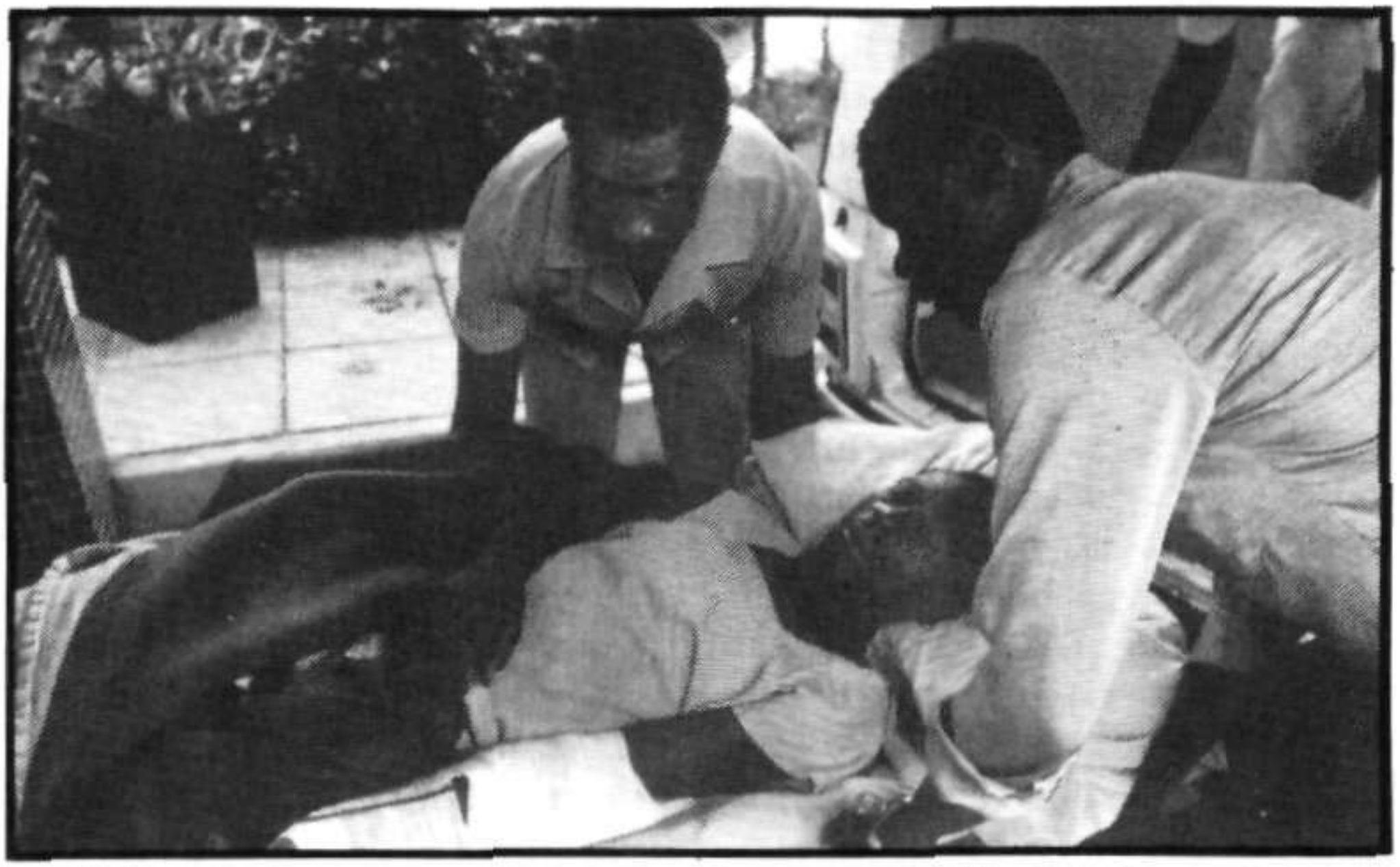
Management usually sees an occupational health service only as a means of preventing ill-health and injury from reducing production and profit. The health

and happiness of workers, and those living near the workplace, are of secondary concern. Also, controlling pollution does not improve profit and is often ignored or poorly handled by management.

This means that management-controlled health services are often very poor. Studies of O.H.S.'s in South Africa show that they mostly function only to patch up injured or sick workers so that the worker does not work less hard and therefore reduce profit. These health services ignore the prevention of sickness and the rehabilitation of injured or sick workers.

The mining industry generally provides a good curative O.H.S. for those workers who are injured or become ill on the job. It also provides rehabilitation services at various mine hopitals for seriously disabled mineworkers. The rehabilitation programme is, however, incomplete. The worker is not rehabilitated into his/her family and community setting. The worker and his family face many hardships in the rural areas as they struggle to cope with inadequate disability pensions, and the lack of adequate water, sanitation and health care systems. As a result, the problems of illness and injury which are caused by dangerous working conditions, become the burden of impoverished rural areas and all those who live

Workers' families may face many hardships in the rural areas



Although the mining industry provides a good OHS, it is incomplete

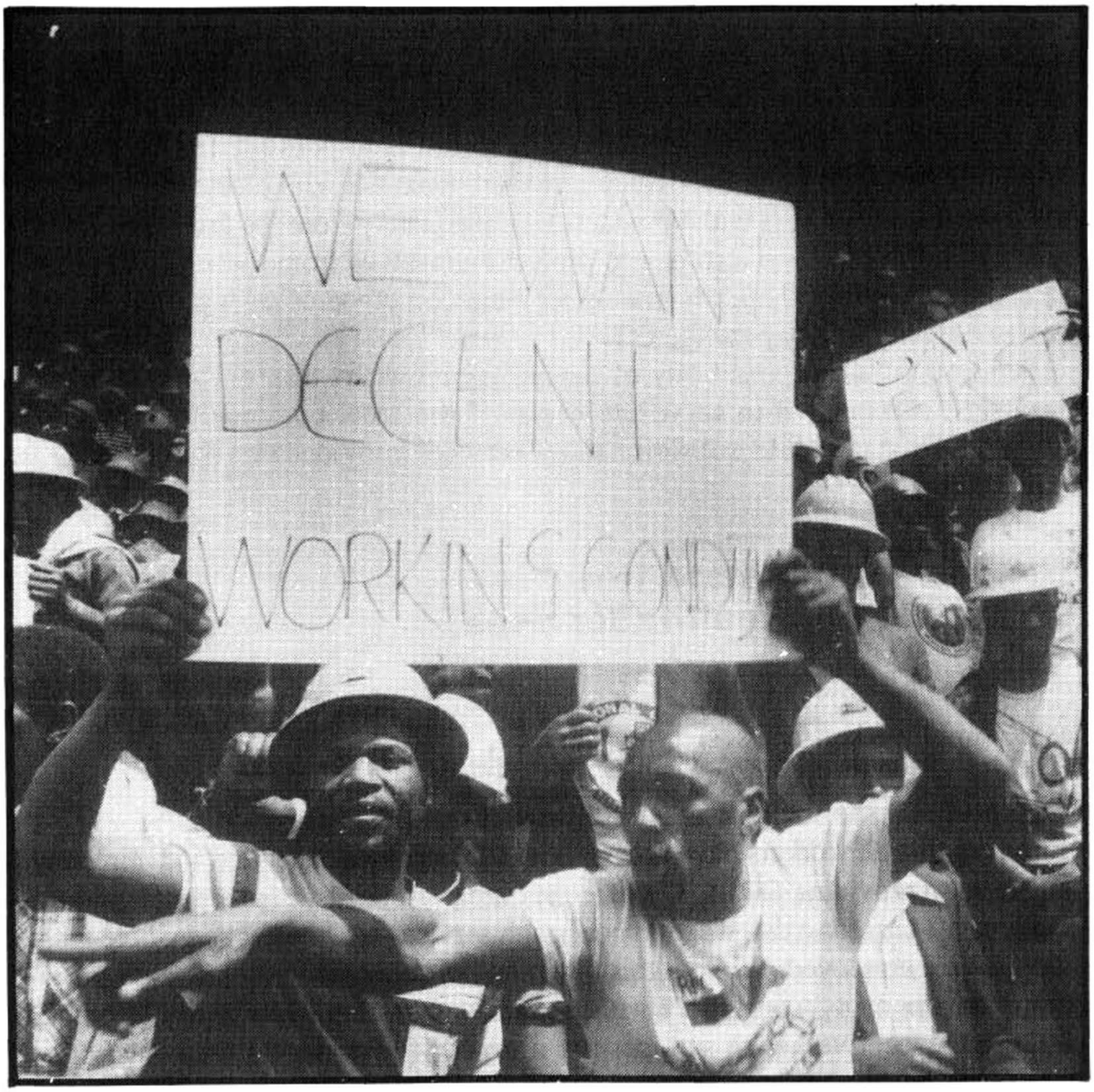
there.

Damage to a worker may only occur years after exposure first started. The worker may only become sick when s/he is old and easily replaced by the company. Chemicals which cause cancer, and deafness caused by noise are examples. Management-controlled O.H.S.'s . often do not provide for these workers. Also, many of the consequences of workplace exposure will not reduce profit and are therefore not taken seriously by management: for example, some substances affect our ability to produce healthy children.

Management controlled O.H.S.'s are usually restricted to workers even if the worker's family lacks the most basic health care.

Workers

Even if the state played no role in O.H.S.'s, an informed and powerful labour movement, operating in conditions where most people are able to find work and where a social security system provides for the elderly and unemployed, could control O.H.S.'s. The result would be an occupational health system capable of promoting health through workplace-based health services. But South Africa is not in this position. The state also actively oppresses the labour movement through police intervention in collective bargaining and detention of trade unionists and union members. Also, many workplaces are not organised or are situated in areas where trade unions are actively discouraged. Workers in these workplaces often have little or no protection from hazards at work.



Workers have made some progress in their demands for a safe and healthy workplace

Although workers have made progress in demands for a safe and healthy workplace, they cannot be really successful until the State accepts its part in protecting us all from the dangers generated by industrial processes.

Who should pay for the Occupational Health Service?

With respect to the financing of occupational health services, there are at least three options. Either the owners of the workplace, or the workers, or the state could be made to pay for these services.

Hazards at work are created neither by the worker nor by society in general. They are caused by demands to increase production and profit without sufficient attention, time and money being given to health and safety. The section of society that demands greater production and profit is responsible for the hazards and is therefore responsible for removing them from the workplace. Workers are often exposed to dangers without benefitting adequately from the profit produced: They should not have to also pay to protect themselves from these dangers. For the state to provide O.H.S.'s is merely an indirect method of asking workers and society in general to pay for the O.H.S.

While it is the responsibility of management/owners to provide O.H.S.'s, if an O.H.S. is extended to serve the needs of the local community as well as workers, the state could subsidise those services provided for non-workplace related sickness.

The role of the state in Occupational Health Services

The state has a large and important role to play in ensuring that work promotes the health of workers and society in general.

Examples of the role that the State should be playing:

- Ensuring that all workers have access to an adequate health service and directing attention to providing O.H.S.'s where they are most needed: for example, where the greatest hazards exist, where other health services are poorest and where most workers are employed. Without this direction, an imbalance in health care arises. For example, many workers are without basic health care while costly resource-intensive executive health services are provided for managers who have other sources of health care.
- Encouraging and promoting democratic structures in the workplace so that constructive negotiations between workers and management occur around health and safety. In many countries, regulations are enacted so that management and workers have equal status concerning health and safety issues. This means workers can determine the priorities of the O.H.S. and appoint staff to run the service.
- Providing a democratic process through which standards can be set, both for the control of hazardous substances in the workplaces, and establishing medical services which would promote health and monitor workers exposed to health risks at work.
- Providing a means of enforcing the standards set. This function is usually performed by inspectors appointed by the state and also by workers themselves.

The Machinery and Occupational Safety Act has attempted to legislate for more safe workplaces, but it is poorly or often not at all enforced

- Using available health care resources in the best manner. For example, by integrating O.H.S.'s and other health services in areas where health provision in general is poor, and by extending O.H.S.'s to serve communities living near factories and mines. Particularly in the mining sector, curative health care is provided for miners while communities around the mines may be without any form of health care.
- Providing information and training to people concerned with health and work, and ensuring that workers are made aware of the health risks they face at work.
- Ensuring that workers do not suffer financial loss through work-injury or sickness and ensuring that workers are properly rehabilitated after accidents or illness.

"Privatisation" of occupational health

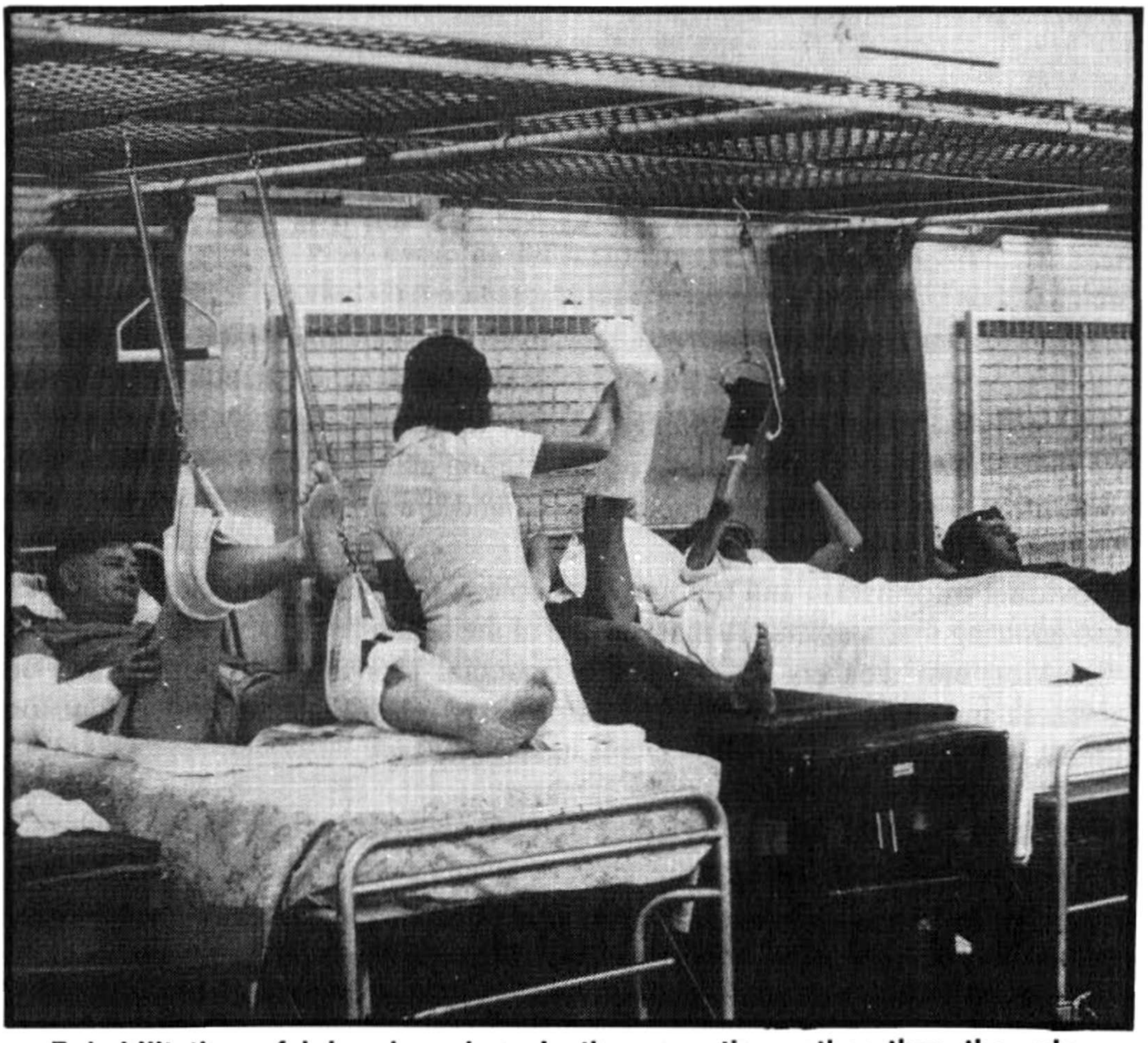
"Privatisation" in South Africa in the context of occupational health is essentially a failure by the state to act. The state has not accepted any of the responsibilities listed above and thus a poor standard of occupational health care is practiced in South Africa.

There are no standards for controlling many hazardous substances, nor are there standards for occupational health services. Deregulation (the granting of exemptions from complying with what regulations and standards do exist) can only worsen the situation. Although the Machinery and Occupational Safety Act has attempted to legislate for more safe workplaces, it is poorly or often not at all enforced. The Occupational Medicine Bill, which was supposed to legislate for health services, has never been tabled.

Many workers have no occupational health care at work, and rehabilitation of injured or sick workers is the exception rather than the rule.

The major reason for private enterprise being able to determine the nature of occupational health provision is that most South African workers have no input into decision-making by the state.

Until labour has direct access to the legislative, occupational health care in South Africa will remain poor and limited.



Rehabilitation of injured workers is the exception rather than the rule

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Tuberculosis screening in industry

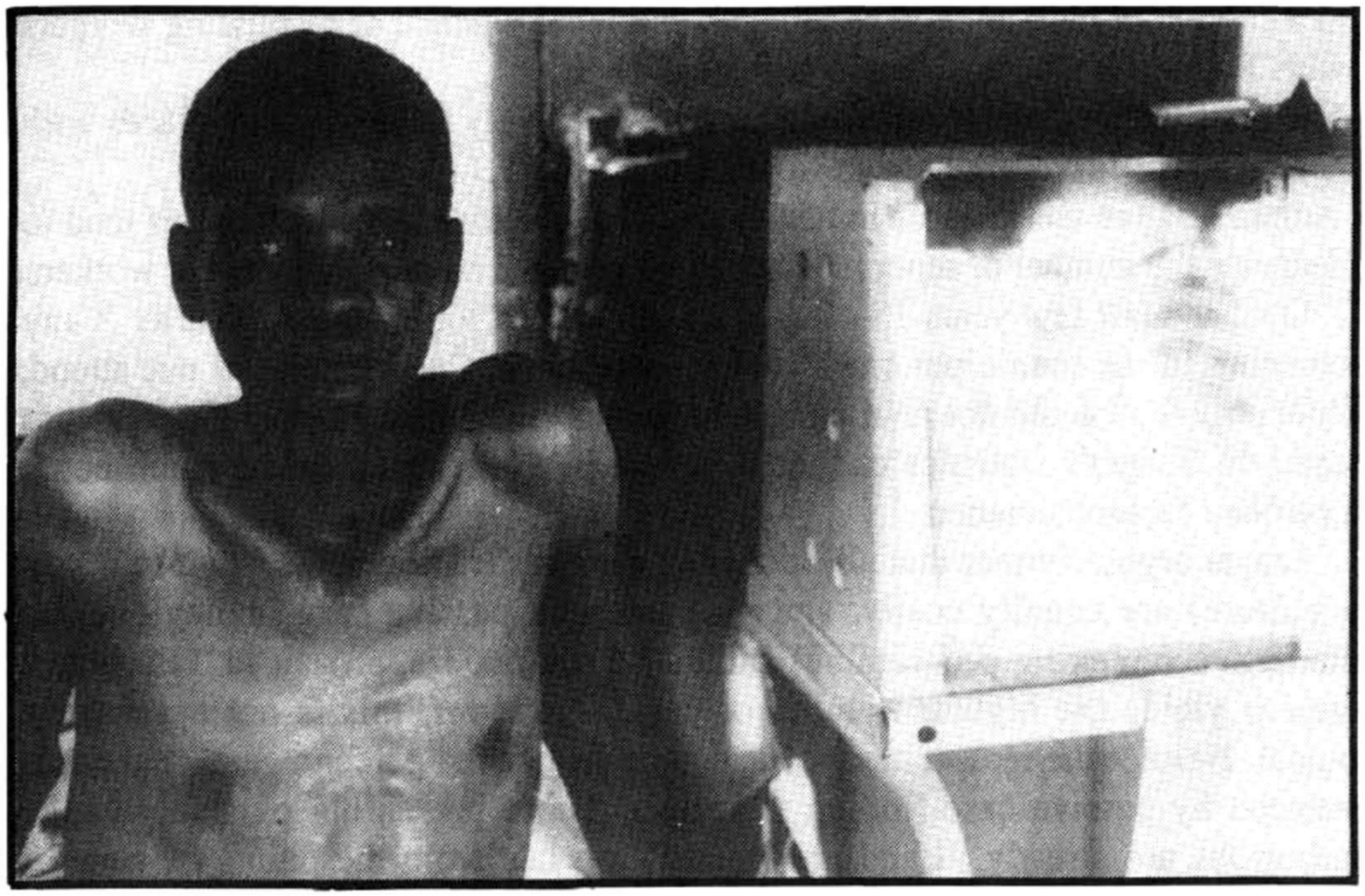
Lobbyists, calling for the privatisation of occupational health services, strongly argue that such moves will introduce far more cost-effective services for workers. Invariably, such moves towards privatisation are often coupled with cut-backs in existing services that are felt to be cost-ineffective.

In an edited version of a recent opinion article, published in the South African Medical Journal,[1] Myers strongly argues against the rationale of phasing out active case-finding methods in order to detect tuberculosis in factory workers and job seekers.

It has recently become official tuberculosis control policy not to do routine mass radiographic screening for factory employees.[2] Policy at present is to screen the following groups: "new" migrant workers (annually), "old" migrant workers (bi-ennially), self or factory referred people with signs and symptoms, and TB case-contacts; and to do pre-employment screening in a high-risk industry when requested by management (M. Zabow, Cape Divisional Council - personal communication).

In consequence, routine X-ray screening, especially periodic examinations of workers in factories, has been progressively abandoned since 1981/1982, while no alternative *active* case- finding procedure has been introduced in its place. The tendency is to rely in practice on *passive* case-finding and screening of contacts. There has been a steady increase in the incidence of TB since 1981,[3, 4] so the abandonment of active case-finding needs to be questioned. The policy change was based on an analysis by Seager[5] of local statistics showing low TB prevalences, and on an acceptance of the 1974 World Health Organization (WHO) guidelines for TB control.[6]

The WHO document recommended discontinuation of indiscriminate X- ray screening. The reasoning behind the recommendation was that, on the one hand, in developed countries TB was not much of a problem and indiscriminate screening was cost-inefficient, while on the other hand, despite high prevalences of TB in developing countries, there were insufficient resources to trace or treat



According to a recent policy, factory workers are no longer entitled to routine mass screening for TB

the disease. Since South Africa is developed enough to have substantial resources for the diagnosis and treatment of TB, and undeveloped enough to have a serious TB problem, the WHO recommendation should not be uncritically accepted. It is noteworthy that the WHO did recommend the discontinuation of selective X-ray screening in high risk groups such as certain factory workers.

Seager uses his analysis of local statistics showing low TB prevalences, to argue against radiographic screening of work seekers and factory employees. Seager feels that if TB prevalences are low, indiscriminate screening (as he refers to it) is cost-inefficient.

He reports a 0,2% prevalence rate for bacteriologically verified cases among "work seekers and factory employees" in the larger urban centres. This contrasts with a rate of 0,3% found in a general urban clinic for all races, and that of 0,7% found in municipal and divisional council clinics in black areas in Cape Town.

It is interesting to note that yields considered in developed countries to be cost-inefficient range from 0,008% to 0,16%.[7, 8]

There are many possible reasons for low prevalences such as those reported by Seager.[5]

- The population screened may be diluted by non-workers.
- Workers tend to avoid screening if they suspect the presence of a chest problem

in a context of high unemployment and employer practice of dismissing workers with TB, and if they are illegal migrant workers.
- Factories making use of screening facilities are likely to be healthier places with healthier work-forces, selecting workers free from TB.
- Administrative weaknesses in health services and attendance difficulties tend to decrease the number of reported cases. This effect is more prominent for workers.

Over the last few years 15-40% of those recalled for examination after X-ray screening in the municipal black township clinic in Cape Town did not attend, while only 4-15% did not re-attend in the general municipal clinic.[2] Conclusions based on Seager's statistics cannot therefore be generalized to the much better controlled factory situation.

Seager argues further that all screening methods (radiographic, sputum smear or culture) are equally costly, and proposes that passive case-finding (i.e. no alternative screening programme) should be the main approach in TB control since it yields the highest number of cases. However, this is not necessarily logical. Neither the real number of actual cases nor the percentage of real cases detected by passive case-finding is known. Those presenting passively to the authorities are already ill and are "found" too late from the points of view of personal health and transmission. In other words, the way in which cases are detected at present tends to maximize the yield from passive case-finding while minimizing the yield from case-finding by selective screening of high-risk populations. The potential for expanded yields from the former may therefore be very low, while that for the latter may be very high.

In the light of these findings, it would seem that passive case finding is not enough. What should be investigated is increased active selective-case-finding among chronic coughers in defined high-risk groups. Methods that should be more closely examined include mini-radiography followed by sputum smear or culture or by means of sputum smear alone. (See original SAMJ article[1] for a cost-effective argument of this suggestion - Editor.)

More reseach could be undertaken into the definition of high-risk groups and the relative effectiveness of different screening methods. It may, for instance, be possible for factory safety representatives (recently brought into being by the Machinery and Occupational Safety Act) to take regular symptom histories from workers for whom they are responsible in the workplace.

1. Myers J. Tuberculosis screening in industry. *S Afr Med J* 1986; 70: 251-252
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5. Seager JR. X-ray case finding in tuberculosis. *TBRI Bull* 1984; 5: 9-13.
6. WHO Expert Committee on Tuberculosis, IXth Report. *WHO Tech Rep Ser* 1974; No 552.
7. Benatar SR. Tuberculosis in the 1980's with particular reference to South Africa. *S Afr Med J* 1982; 62: 359-364.
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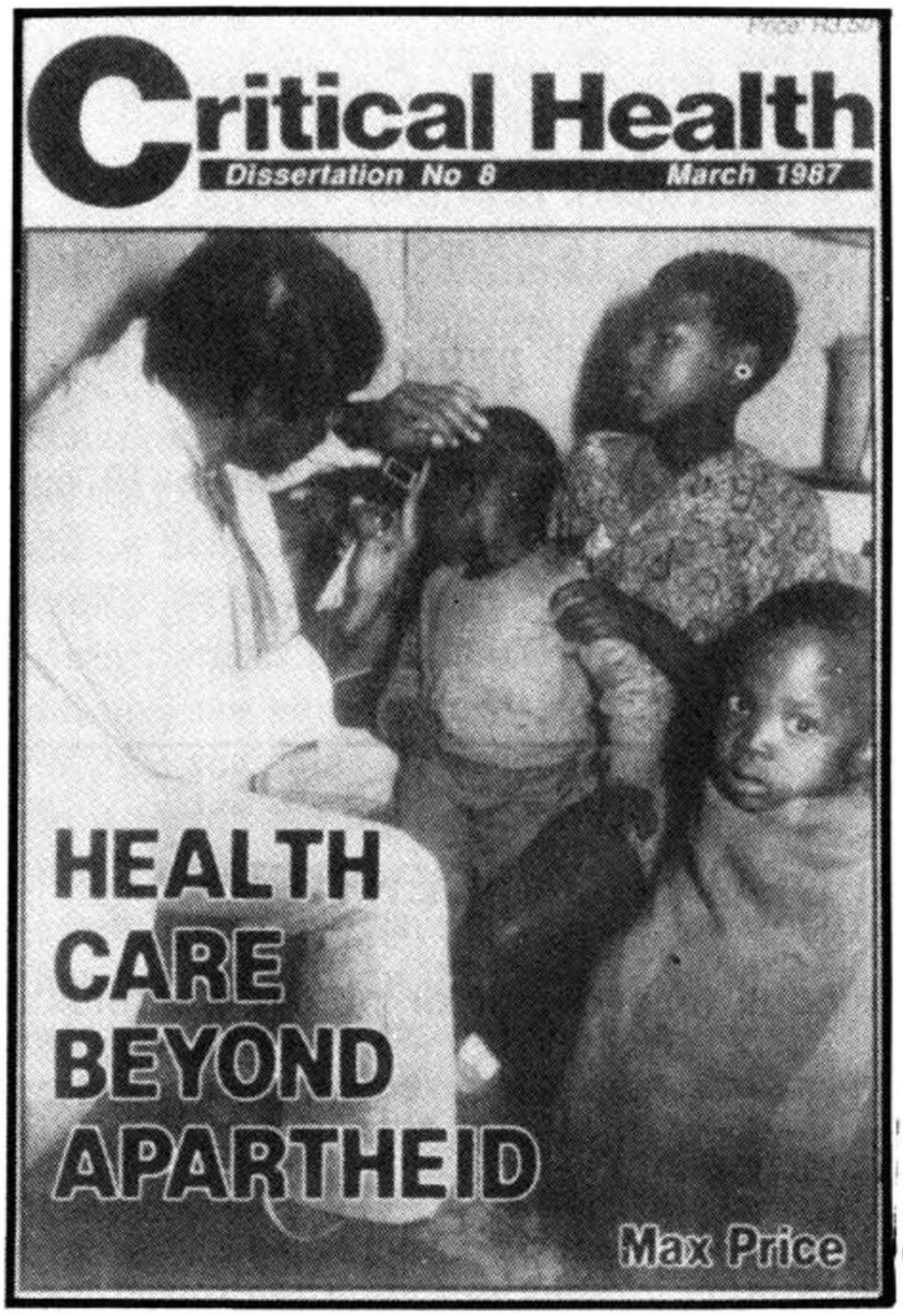

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The current trend in South Africa towards increased privatisation of health care has given rise to a debate on the future economic organisation of health services. This dissertation is a contribution to that debate. It posits specific objectives for the re-organisation of health services which would lead to greater public ownership, with a combination of public and private methods of financing.

At present, the implementation of these suggestions is obstructed by social and political factors such as the status quo in health care, the power of the medical profession, and the legacy of Apartheid. Any comprehensive set of proposals and policies will have to take cognisance of these factors. This dissertation attempts to take merely the first step in exploring proposals for improving the provision of health care to all South Africans.

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