

# HASA NEWS

*Exploring new healthcare frontiers*



FEBRUARY 2011

**CANCER CASES  
ON THE INCREASE**

**2003  
NATIONAL  
HEALTH ACT  
Amendment Bill**



STATE OF THE NATION

# THE ROLE OF THE HOSPITAL ASSOCIATION OF SOUTH AFRICA

**T**he Hospital Association of South Africa (Hasa) is a confederation of private hospitals and ambulatory clinics, operating on a non-profit basis, representing the collective interests of private hospitals in South Africa in respect of economic and social policy and other areas, as agreed to by its members.

The Association represents a total of 27 777 beds, about 94% of the beds in the private hospital sector. Hasa is seen by government to be the official representative body for the industry and is recognised by other stakeholders as the mouthpiece of the industry.

The Association does not market individual hospitals, neither does it enter into funding contracts on behalf of its members.

The Association's affairs are governed by a Board of Directors, elected by the members, which is fully representative of the Association's membership base.

## THE OBJECTIVES OF THE ASSOCIATION INCLUDE:

- Promoting the development of an economic and social system, based on the principles of justice, a free market economy, individual entrepreneurship and equal opportunity;
- Initiating, influencing and commenting on proposed legislation in the interests of its members;
- Acting as a representative on behalf of its members to commissions, committees and other institutions, as decided by its members, including the Health Professions Council of South Africa, South African Nursing Council, South African Medical Association, Council for Medical Schemes, Road Accident Fund Board, National Health Information Systems Committee (Department of Health), Commission for Occupational Injury and Diseases, Health and Welfare Sector Educational Training Authority, Council for Health Service Accreditation of Southern Africa and the Private Health Forum;
- Liaising with other international bodies, such as the British Association of Private Hospitals, the American Hospital Association and the Australian Hospital Association;
- Communicating and consulting with its members on important national and international developments which may impact on South African healthcare interests;
- Acting as a communication hub to inform and advise its members through, amongst others, workshops and conferences at both regional and national levels, a monthly newsletter, LegalWatch, NursingWatch, HasaWatch as well as a prestigious annual publication, Health Annals;
- Investigating complaints and acting as a mediator in dispute resolutions in matters arising from patient or member complaints; and
- Marketing the competence and ability of its members to the public, which is accomplished through media liaison, press releases, public addresses and the placement of advertorials in the press.

FEBRUARY 2011

## CONTENTS

- 2 STANDARDS FOR SYRINGES AND NEEDLES
- 3 DOCTORS WARN ON FATE OF EASTERN CAPE HOSPITALS
- 3 HEALTH AWARENESS DAYS
- 4 STATE OF THE NATION ADDRESS
- 5 HEALTH MINISTER INTENSIFIES FIGHT AGAINST AIDS
- 6 CANCER TO EMERGE AS A CHALLENGE IN AFRICA AS LIFESTYLES CHANGE
- 9 NATIONAL HEALTH ACT, 2003 AMENDMENT BILL
- 11 NEWS IN BRIEF
- 12 NURSE YOUR HEART

For further information on Hasa, access our website [www.hasa.co.za](http://www.hasa.co.za) or tel 011 478 0156.





## HASA NEWS

House VII, Visiomed Office Park,  
269 Beyers Naudé Drive, 2195  
Northcliff  
PO Box 4038, 2118 Cresta  
website [www.hasa.co.za](http://www.hasa.co.za)

### EDITOR AND PRODUCTION MANAGER

**Lucas Malambe,**  
Executive Officer:  
Corporate Communications

### ADVERTISING SALES AND SUBSCRIPTIONS

**Dawn Adams,**  
Administration Officer  
tel (011) 478 0156, 7,8,9  
fax (011) 478 0410  
email [contact@hasanet.co.za](mailto:contact@hasanet.co.za)

### LETTERS TO THE EDITOR/ ARTICLE SUBMISSIONS

tel (011) 478 0156, 7,8,9  
fax (011) 478 0410  
email [contact@hasanet.co.za](mailto:contact@hasanet.co.za)

### BOARD OF DIRECTORS

- Mr R Allie,** *Melomed Holdings*  
**Ms M S F Da Costa,** *Netcare Limited*  
**Mr J du Plessis,** *Netcare Limited*  
**Dr V L Lithakanyane,**  
*Netcare Limited*  
**Dr N S Matlala,** *Chairperson,*  
*Medi-Clinic SA*  
**Mr A S Meiring,**  
*Psychiatric Focus Forum*  
**Dr D Mji,** *eThekweni Hospital*  
*& Heart Centre*  
**Mr A A Nana,** *Lenmed Clinic*  
**Mr A M Pyle,** *Life Healthcare*  
**Mr P J Scott,** *Life Healthcare*  
**Mr R Buys,** *Medi-Clinic SA*  
**Dr K I M Shongwe,**  
*Deputy Chairperson,*  
*Life Healthcare*  
**Mr B Valodia,** *Medi-Clinic SA*  
**Mr M C van den Berg,**  
*Zuid-Afrikaans Hospitaal*  
**\*Dr S Vasuthavan,**  
*Life Healthcare*  
**Adv K Worrall-Clare,**  
*HASA CEO & Legal EO*  
**Mr O F A K Wypkema,**  
*Arwyp Medical Centre*

\*Ex officio

### EDITORIAL POLICY

Hasa News is a monthly publication. The views expressed in this publication are not necessarily those of the editor or Hasa. Copyright of all material in this publication is vested in the authors thereof. Requests to reproduce any of the material should be directed to the editor.



# CHALLENGES AHEAD

**Lucas Malambe, Editor Hasa News**

**As always the rising cost of medical insurance premiums generates a lot of debate. More often than not finger-pointing drives this important debate at the expense of understanding the underlying drivers of medical inflation such as the quadruple burden of illness, staff shortages, regulatory challenges and the global economic downturn. For instance, a PWC report, commissioned by America's health insurance planners, found that at least 43% of the premium cost is as a result of an increase in consumer demand in the United States.**

According to a new study released on World Cancer Day in February cancer deaths in Africa are projected to double by 2030, owing to growth and ageing of the population, if preventive measures are not widely applied (see page 6). Reading this increasing utilisation in conjunction with the shortage of healthcare skills is disheartening.

Despite the nursing skills scarcity (see page 8) the South African healthcare sector is also facing a dearth of high-level healthcare skills such as doctors and specialists. Rural areas and state hospitals, with more than 4 000 vacancies in the public sector, are the hardest hit.

The glaring inequities in South Africa's healthcare are the result of the legacy of apartheid and inadequate policy efforts that exacerbated underlying challenges, such as the poor quality of publicly provided healthcare and the influence of insurance status on utilisation patterns (Gilson and McIntyre, 2007).

The gross disparity is pronounced in urban and rural healthcare facilities. Figures for specialists per million people demonstrate that a skewed trajectory is ballooning towards the wealthy cities of the Western Cape and Gauteng. The then MEC for Health in Mpumalanga, Fish Mahlalela, reported in March 2008 that Mpumalanga had a doctor vacancy rate of 54%, that is significantly higher than the national average of 37%.

Mahlalela's observation remains as table 1 (see page 2) shows that the number of Gastroenterologist, Neurologist, Pulmonologist, and Vascular Surgeons in Mpumalanga remains zero. The other poor provinces such as Limpopo, Eastern Cape and North West, does not fare any better.

Despite having the largest health professional production capacity in Africa, SA has ended up with a massive shortage of clinical staff in the public sector and an even

more dire need in rural areas.

Meanwhile, demands on the healthcare system are rapidly escalating because of the quadruple burden of diseases plaguing the country. Marszalek and De Villiers (2006), in a retrospective study of hospital admissions over a three-year period, presented depressing data of morbidity distribution reflecting that lifestyle, alcohol, and violence-based illnesses and infectious conditions such as HIV/Aids and multi-drug tuberculosis are taking root in SA.

It will add a lot of value into the debate around the costs of medical aid premiums to acknowledge the role played by these underlying cost drivers.

Research-driven debate is critical as it shapes future policy on health delivery. Finger pointing as opposed to fact-based inputs, especially in the media, will only leave the public with a biased impression of the private health sector. This will stymie the public's participation in such issues of national importance.

One issue of national importance is the much-awaited policy document on National Health Insurance (NHI). The official word is that the Ministerial Advisory Committee on NHI has finalised its work and the ministry is ready to sell it to legislatures. The Minister of Health Dr Pakishe Motsoaledi, told journalists in February that the Committee drew up its first draft of an NHI policy a year ago, but was asked by the Cabinet to do more work on primary healthcare, the cost of the NHI and its economic benefits. He said the Department of Health had also been hard at work during the past year, auditing health institutions, staff and equipment in preparation for implementing the NHI. If Cabinet approves, the white paper will follow the National Health Act (NHA) 2003 Amendment Bill, published in January to propose an implementation of what appears to be standardised quality control measures across the public and private hospital sectors (see page 9).

(CONTINUED ON PAGE 2)

(CONTINUED FROM PAGE 1)

TABLE 1: MEDICAL SPECIALISTS STATISTICS - FEBRUARY 2011

MEDICAL SPECIALISTS	Total	Gau	WC	KZN	Mpum	NW	FS	Lim	EC	NC
Anaesthetist	1,190	520	300	193	22	33	50	s10	53	9
Cardiac & Thoracic Surgeon	108	46	26	17	1	3	8	1	5	1
Cardiologist	169	78	43	29	2	1	6	1	9	0
Dermatologist	179	68	53	30	3	3	8	3	9	2
ENT	261	105	58	52	6	7	11	6	13	3
Family Physician	392	121	81	80	24	21	26	9	23	7
Gastroenterologist	82	45	20	13	0	0	2	0	2	0
General Practitioner	13,976	4,854	2,547	2,371	737	743	703	698	1,076	238
Gyn & Obs	860	359	200	142	23	29	34	19	48	6
Neurologist	125	58	29	23	0	1	10	1	3	0
Neurosurgeon	140	64	34	18	4	3	6	1	8	2
Oncology	173	61	53	23	3	4	16	4	7	2
Ophthalmologist	352	146	84	56	8	11	12	7	22	6
Orthopaedic Surgeon	603	225	147	99	13	15	32	7	30	5
Paediatricians	815	64	205	142	14	24	37	18	80	5
Pathologist	370	206	103	58	5	9	36	3	16	2
Physician	714	298	175	112	13	22	43	8	39	4
Plastic Surgeon	150	67	49	20	1	0	3	0	10	0
Psychiatrist	570	227	182	75	4	12	29	12	25	5
Pulmonologist	80	35	26	11	0	0	2	0	6	0
Radiologist	498	323	106	81	8	10	21	11	27	2
Surgeon	568	206	128	121	11	22	26	9	37	8
Urologists	207	80	48	41	5	9	10	2	9	3
Vascular Surgeons	38	17	12	6	0	0	1	1	1	0

Source: MEDpages

Hasa is known for its support of quality control for the provision of healthcare services in the public and private hospital sectors.

The NHA Amendment Bill proposes the establishment of the Office of Health Standards Compliance designed to monitor the quality of healthcare services. Although Hasa is still studying the Bill and not yet in a position to provide detailed commentary, the Bill is not that clear on issues pertaining to jurisdiction and the powers of

the inspectors in relations to other authorities.

The Bill must clarify issues surrounding the jurisdictions of existing statutory councils, the South African Police Services (SAPS) and proposed consumer regulatory bodies established in terms of the Consumer Protection Act. For instance, the SAPS is responsible for any criminal offence committed by healthcare providers while the Health Profession Council of SA deals with professional and clinical misconduct.

REFERENCES

Gilson, L. & McIntyre, D. (2007). Post-apartheid challenges: household access and use of care. *International Journal of Health Services*. 37(4): 673-691  
 Mahlalela, F. (2008). 2008/09 Policy and Budget Vote Speech, 13 June 2008.  
 Marszalek, J. & De Villiers, .P.J.T. (2006). Morbidity profile of admissions to GF Jooste Hospital, Manenberg, Cape Town, SAFP.Vol 48, No 6 -July 2006  
 PricewaterhouseCoopers. (2006). The Factors Fueling Rising Healthcare Costs 2006, accessed 2011-01-18.

# STANDARDS FOR SYRINGES AND NEEDLES

The following two standards were published on 9 Feb 2011 and supersede the previous editions published in 1998:

**SANS 1124-1, Syringes and needles**

(sterile-packed for single use) Part 1:

Hypodermic needles

**SANS 1124-2, Syringes and needles**

(sterile-packed for single use) Part 2: Syringes



**There are the significant differences between the two editions:**

- The sterilisation date is no longer a labelling requirement for needles or syringes.
- The tolerance on the length of a needle with a nominal length of 40 mm is (36-40) mm and not (37-42) mm as in the previous edition.
- The requirement for the length of the graduation lines of syringes no longer applies.
- The provision of additional graduation lines between the prescribed intervals is not precluded.
- The following statements are no longer required for syringes:
  - "Not to be used with paraldehyde (or their equivalent)",

- the words "Pyrogen free" or "bacterial endotoxin free", and
- the instruction to "destroy the contents of any immediate package that is not intact".

- An indication whether or not syringes (or their packaging) are latex free, has been added as a requirement.

Furthermore, general requirements have been published to replace the adoption of the previous edition of ISO SANS 15223-1/ISO 15223-1, Medical devices - Symbols to be used with medical device labels, labelling and information to be supplied in Part 1.

For further details regarding any changes, the latest copy of the standards can be obtained from sales@sabs.co.za.



# DOCTORS WARN ON FATE OF EASTERN CAPE HOSPITALS

TAMAR KAHN: Business Day, 9 February 2011. SAPA, 8 February 2011

Rural doctors have drawn parliament's attention to the financial crisis facing provincial-aided hospitals in the Eastern Cape, warning that several hospitals faced imminent closure if they did not receive more funds from the province. The hospitals are earmarked for a takeover by the Eastern Cape health department on April 1 2011, but the doctors warned that services could collapse before then. Provincial-aided hospitals receive 90% of their budget from the government, but retain the independence to hire and fire staff, and issue their own tenders for supplies. The Eastern Cape originally had 18 provincially-aided hospitals, many of which were initially funded and built by local communities, some as far back as the 1940s. So far, 11 have been taken over by the province, one is resisting the move, and the rest will be transferred to provincial control on April 1. The province's plan is to "centralise" its management of small rural hospitals in the capital Bisho, and, at the same time, cut rural resident doctors' session hours from 40 to 20 a week. Documents presented by the doctors to parliament's portfolio committee on health show Indwe and Lady Grey hospitals - which faced budget shortfalls of R2,37m and R4,44m respectively - were in the worst position, followed by Adelaide and Sawas hospitals, which were R1,98m and R1,3m in the red respectively. Molteno Hospital was short of R680 000, while Sterkstroom Hospital needed another R400 000 to continue services.

Jessica Johnson, a member of the Martje Venter Hospital board, said

provincial-aided hospitals were concerned about the lack of clarity regarding the transfer of assets when the facilities were taken over by the province. She said hospitals that had been taken over with overdrafts, faced a situation where the banks wanted to take the hospital buildings, which belonged to the communities. Johnson expressed concern about the rates the Eastern Cape health department was prepared to pay for supplies, telling MPs that her hospital had been able to source bread at R5,50 a loaf and was shocked to discover the department was paying its supplier R22,50 a loaf. Dr Nqabisile Nyushmann, a medical officer at Sawas Hospital, raised concern about changes to the number of sessions doctors were allowed to work when the provincial health department took over. Since few doctors want to work in rural areas, many provincially-aided hospitals paid for private doctors on a "session" or hourly basis. Nyushmann warned that limiting the session work to just 20 hours a week made it difficult to attract staff, as there were too few patients in the region who could afford to pay private fees to supplement a session doctor's income. Dordrecht doctor Susan Christiane said the department's plan to reduce the sessions would see many of them quit. She said that of the rural doctors serving at hospitals in small towns across the north-eastern region of the province; all but two had indicated they would go. She labelled the provincial department's decision an insult.

Christiane also highlighted the

massive impact AIDS was having on rural communities, and how it was limiting small hospitals' ability to deal with other ailments. She emphasised that HIV had so overwhelmed the health system, that there was no money for anything else. It's just all concentrated, pneumonia, gastro, coming into our little hospital. We have to treat them, the debilitated people. Committee chairperson Monwabisi Goqwana said members would examine the documents tabled at the briefing, make recommendations, and take these up with the National Health Department.

## HEALTH Awareness

MARCH 2011

### TB AWARENESS MONTH

- 8 International Women's Day
- 10 World Kidney Day
- 20 World Head Injury Awareness Day
- 21 Human Rights Day
- 21 World Down Syndrome Day
- 21- 27 World Salt Awareness Week
- 24 World TB Day

# STATE OF THE NATION ADDRESS

In his State of the Nation address on 10 February 2011, President Jacob Zuma touched briefly on healthcare - listed as one of the government's top priorities. The following is extracted from the President's speech:

"In the health sector, this year, we will emphasise the appointment of appropriate and qualified personnel to the right positions. We need qualified heads of department, chief financial officers, hospital chief executive officers, district health officers and clinic managers. We plan to revitalise 105 nursing colleges countrywide, to train more nurses. We are also planning to open a medical faculty at the Limpopo Academic Hospital to train more doctors. The renovations and refurbishments of hospitals and clinics will continue. Given our emphasis on women's health, we will broaden the scope of reproductive health rights and provide services related to amongst others, contraception, sexually transmitted infections, teenage pregnancy and sanitary towels for the indigent. On the fight against HIV and Aids, we have revitalised our programmes and promote various prevention measures including medical male circumcision, prevention of mother to child transmission and the promotion of HIV testing. The testing has been popularly taken up around the country. Just over 5 million HIV tests have been done since the launch of the testing campaign in April last year. Over the past year, work has continued to develop the National Health Insurance policy and implementation plan. Government will soon be releasing the policy document for public engagement."



## SA KIDS ARE GETTING FATTER SMOKING, DRINKING MORE...(?)

SAPA, 9 February 2011

**S**outh African children are getting fatter, and the number of those drinking and smoking in adolescence is peaking, according to a new study. Overall, they scored a disappointing C-minus in the Healthy Active Kids SA 2010 Report Card. This was due to unhealthy eating, smoking, drinking and lack of physical activity, the study said. It



expressed concern over the proportion of overweight and obese children, which had increased from 17% in the last report card, in 2007, to 20% last year. Only 42% of young people participated in sufficient vigorous physical activity, down from 45% in 2007. Hours dedicated to television or computers stood at 30%, up from 25% in 2007. Less than 70% of high school learners had regularly scheduled physical education classes, and the rates were lowest among schools in poor communities. Unhealthy eating was also a major concern, the study said. Nearly 30% of teens consumed fast food two to three times a week. One of the major barriers to healthy eating was affordability of healthy food, which cost almost twice as much as the unhealthy equivalent. The prevalence of smoking among adolescents had remained constant since 2007, despite a hike in the age at which young people could legally buy cigarettes from 16 to 18. Smoking was more common among boys than girls, and in urban areas. One in five teenagers surveyed admitted to being current smokers. This was well above the global prevalence for children and youth. Although there were signs of greater awareness and an increasing number of intervention programmes by government such as introducing physical education into the curriculum, and encouraging schools to have vegetable gardens, this had yet to yield results, study co-author Professor Vicki Lambert said. The Healthy Active Kids SA Report Card 2010 drew on over 95 published studies and reports.

# HEALTH MINISTER INTENSIFIES FIGHT AGAINST AIDS

CHANDRÉ PRINCE & HARRIET MCLEA: The Times, 15 February 2011  
VUVU VENA: Mail & Guardian, 15 February 2011

Health Minister Aaron Motsoaledi has vowed to fight the spread of HIV among the young with the “gloves off” - and he will not “hold back any punches”. His hard-hitting stance follows the launch of a testing campaign involving first-year university students, First Things First, at Wits University, Johannesburg. Two weeks ago, a furore erupted over plans for HIV testing at schools. There were concerns that children’s rights would be violated. Motsoaledi said he failed to understand the resistance to the planned campaign at schools while thousands were dying of the disease. He said South Africa was in denial and was not doing what it should to fight the disease. Motsoaledi said the planned testing campaign at schools was being opposed from an unlikely quarter - non-government organisations that themselves “silently” tested school pupils for HIV. Motsoaledi could not say exactly how much the new testing campaign for pupils will cost.

He said the Department of Health had set aside R1,4-billion for the 2010-2011 financial year and would use an additional R180-million from nine provincial education departments. The departments of health

and of education are spearheading the schools testing campaign, partnered by the departments of social development and of public service and administration.

Motsoaledi said a lot of money meant for HIV awareness was spent on workshops, pamphlets and T-shirts, but SA needed a more hard-hitting approach. The HIV Counselling and Testing Campaign will be implemented at all schools and at 17 universities countrywide. It is intended to encourage pupils and students to know their HIV status and receive treatment. The voluntary testing programme is to be implemented first at universities - at which first-year students are believed to be at high risk of being infected - and later at schools. The next phase of the programme will include testing workers on farms and mines, and in industrial areas. Motsoaledi said he had asked churches and traditional leaders to participate. At schools, however, the “finer details” of the testing campaign had yet to be finalised and he hoped the detail would be revealed in the next two months. The department has beefed-up staff numbers and infrastructure to ensure the success of the programme. Antiretroviral drug dispensing sites have

been increased from 490 to 1 500 and the number of nurses allowed to start patients on ARV treatment has risen from 250 to 2 000 between April 2010 and January. The department aims to have 4 000 ARV-dispensing clinics by June. Motsoaledi has signed an agreement with Basic Education Minister Angie Motshekga that includes establishing a programme to provide reproductive health treatment to pupils. Eventually, said Motsoaledi, every school would have access to nurses, psychologists, social workers and trained counsellors dedicated to looking after its pupils. South Africa has only 0,7% of the world’s population but 17% of its HIV victims, he said. Statistics show that HIV infection is higher among girls than boys of the same age. The increasing number of teenage pregnancies, Motsoaledi said, seemed to of far greater concern than HIV. He said this proved that children were having unprotected sex, which made them more vulnerable.

The university campaign involves a public-private partnership between Innovative Medicines of SA, the SA National AIDS Council, Higher Education SA and the US’s HIV fund, PEPFAR. There are plans to introduce the campaign at further education and training colleges, and at universities of technology. A 30-minute DVD has been produced that provides HIV-related information “in a student context” and can be shown at university residences and at orientation lectures. Val Beaumont, executive director of Imsa, said this was the most ambitious HIV testing campaign in the world, and aimed to counsel and test 15 million South Africans for HIV by June 2011. She said the campaign was aimed at South Africa’s first-year university students, and was not just another campaign. She said it was fresh and contemporary and was confident that it would have a lasting behavioural legacy among students to do things differently. Beaumont said students who participated in the campaign and signed the pledge stood a chance to win a Toyota Yaris Zen, donated by Toyota. She said the sponsors thought it was good to incentivise behavioural changes, but lasting prize was a generation of future leaders in our communities who would be true to themselves and their peers, who would respect each other and lay the foundation stone for an HIV-free society.



# CANCER TO EMERGE AS A CHALLENGE IN AFRICA AS LIFESTYLES CHANGE

CANCER IS EMERGING AS ONE OF THE FASTEST GROWING CAUSES OF DEATH IN AFRICA WITH ABOUT 681 000 NEW CANCER CASES AND 512 400 CANCER DEATHS OCCURRING IN 2008, ACCORDING TO THE INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC).

The study by IARC also predicts that the numbers will double in two decades to 1,28 million new cancer cases and 970 000 cancer deaths, as a result of people living longer and poor lifestyles (see table 1).

In a retrospective study of hospital admissions over a three-year period, Marszalek and De Villiers (2006) also painted a gloomy picture of morbidity distribution, reflecting the ills affecting South African urban society. Graph 1

shows that admissions from victims of trauma (ICD category S or T), disease of the circulatory system (I) and infectious illnesses (A or B) dominate. These types of admissions require high-care services, more time in hospital and more surgical wards.

Prescribed Minimum Benefits also drive utilisation up, as those who suffer from previously uninsured conditions are now accessing healthcare.

It will also be interesting to study the impact that HIV/Aids, obesity and injuries

have on medical inflation. The financial cost of cancer is extensive due to the depletion of resources used for treatment as well as morbidity and mortality costs. The American Cancer Society and LIVINGSTRONG (2010) asserts that utilisation of treatment resources puts upward pressure on medical inflation as providers respond to the escalation of utilisation.

The IARC (2010) report also recommends that due to the role of obesity, smoking, preventable infectious illnesses and alcohol consumption prevention is better than cure. Policy makers will have to redirect resources towards prevention and early detection programmes as cancer is difficult to cure unless it is discovered early.

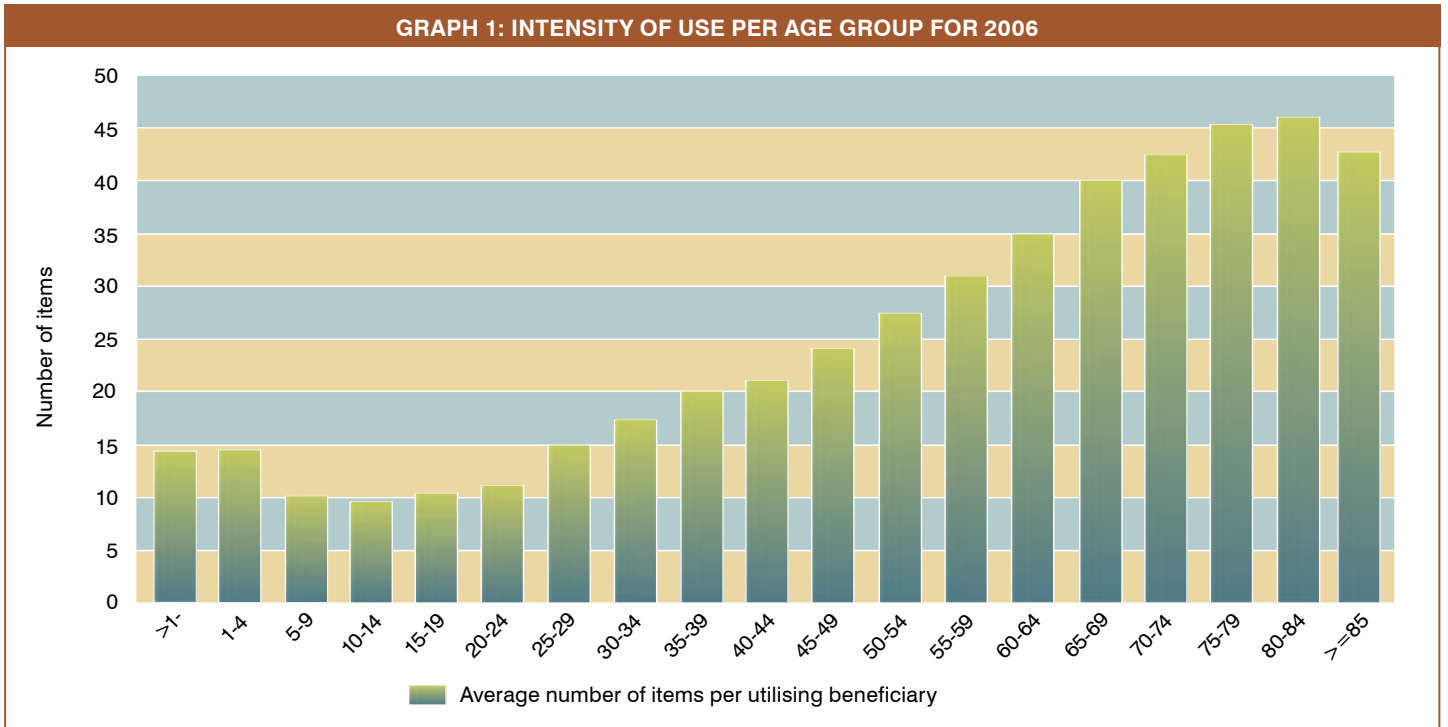
TABLE 1. ESTIMATED NUMBER OF NEW CANCER CASES AND DEATHS BY WORLD AREA, 2008\*

	CASES			DEATHS		
	Male	Female	Overall	Male	Female	Overall
<b>Eastern Africa</b>	100,800	120,200	221,100	85,400	88,300	173,700
<b>Middle Africa</b>	29,500	37,400	66,900	25,600	27,600	53,200
<b>Northern Africa</b>	81,500	82,900	164,400	65,400	55,400	120,800
<b>Southern Africa</b>	40,600	38,600	79,200	29,300	25,500	54,800
<b>Western Africa</b>	72,500	111,600	184,100	61,300	78,000	139,300
<b>Eastern Asia</b>	2,135,300	1,585,400	3,720,700	1,511,800	928,600	2,440,400
<b>South-Central Asia</b>	651,100	772,000	1,423,100	496,800	483,200	979,900
<b>South-Eastern Asia</b>	336,700	388,800	725,600	258,600	242,400	501,000
<b>Western Asia</b>	118,500	104,800	223,300	86,700	64,400	151,200
<b>Caribbean</b>	42,800	36,500	79,300	26,300	21,500	47,800
<b>Central America</b>	84,000	92,600	176,600	52,500	55,800	108,300
<b>Northern America</b>	831,800	772,100	1,603,900	332,500	305,900	638,300
<b>South America</b>	318,000	332,100	650,100	200,600	185,300	385,900
<b>Central and Eastern Europe</b>	494,600	490,600	985,200	351,700	283,000	634,800
<b>Northern Europe</b>	248,400	231,800	480,200	126,400	116,300	242,700
<b>Southern Europe</b>	398,800	315,000	713,900	225,000	155,500	380,500
<b>Western Europe</b>	569,600	464,700	1,034,300	258,900	204,900	463,800
<b>Australia/New Zealand</b>	70,300	56,700	127,000	27,600	21,400	49,100
<b>Melanesia</b>	3,300	3,700	7,000	2,600	2,500	5,100
<b>Micronesia</b>	300	400	700	200	200	400
<b>Polynesia</b>	600	600	1,100	300	200	600

\* Excludes nonmelanoma skin cancer.

Source: GLOBOCAN 2008.

GRAPH 1: INTENSITY OF USE PER AGE GROUP FOR 2006



A study to identify environmental risk factors for non-communicable diseases in an urban township, found that there was generally a shortage of healthy, low-fat food and little fresh fruit and vegetables available. Even so a large percentage of African women were overweight or obese, few perceived themselves to be so ([www.cansa.co.za](http://www.cansa.co.za)). This is cause for concern when one views the proportion of cancer causes by major risk factors and level of economic development in Figure 1.

Strengthening prevention and early detection systems will also reduce the pressure on medical inflation. In South Africa, over the period 1990 to 2001, the medical component of the consumer price index (CPI) escalated at a compound rate

that far exceeded the all-items CPI inflation rate, by an average of 5 percentage points a year. Nonetheless, data covering the recent years demonstrates that medical inflation is leveling off under the trajectory of the headline CPI, and, for the second year running, hospital costs have been below medical inflation, which teeters at 6,1%.

It is, therefore, imperative for the country's health economists to analyse the effects of higher consumption on price and its effect on hospital expenditure as well as the complex interplay of ageing, better and safer medical technology, and higher chronic disease incidences. It will strengthen the debate around medical inflation.

REFERENCES

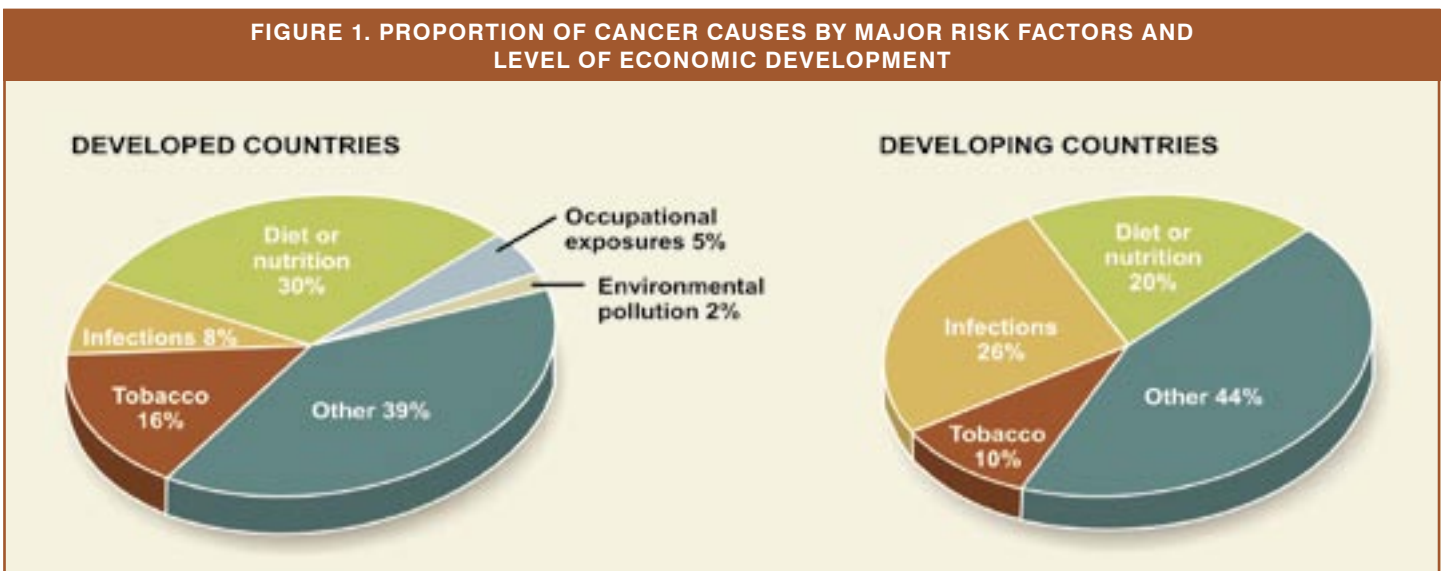
American Cancer Society and LIVESTRONG. The Global Economic Cost of Cancer Atlanta: American Cancer Society;2010.

International Agency for Research on Cancer. (2010). Global Cancer Facts & Figures. 2nd Edition. [internet]. <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-027766.pdf>

Marszalek, J. & De Villiers, .P.J.T. (2006). Morbidity profile of admissions to GF Jooste Hospital, Manenberg, Cape Town, SAJP Vol 48, No 6 -July 2006

Schüssler,M. (2006). An Introduction to the Private Healthcare Sector, Health Annals. 2006

FIGURE 1. PROPORTION OF CANCER CAUSES BY MAJOR RISK FACTORS AND LEVEL OF ECONOMIC DEVELOPMENT



# SOUTH AFRICAN HEALTH WORSE THAN OTHER BRIC COUNTRIES

**South Africa's proportional health expenditure is the highest in comparison to the BRIC group of countries, but our health outcomes are generally worse, says the South African Institute of Race Relations.**



Spending is at 9% of the country's gross domestic product (GDP), followed by Brazil's 8% and Russia's 5%. China and India both spend the lowest proportions at 4%.

These figures appear in the latest South Africa Survey, published by the Institute in Johannesburg. With 49 million people, South Africa has the highest incidence of tuberculosis (TB) at 960 per 100 000 people. China's population of 1,32 billion has an incidence of 97 while Brazil's 192 million people have the lowest incidence at 46. Russia's 142 million people have an incidence of 107 and India, with 1.14 billion

people, is at 168. About 62% of children are immunised against measles in South Africa yet in Brazil and Russia, 99% of children are immunised. China and India have 94% and 70% of children immunised respectively. Life expectancy at birth is 51 in South Africa and in China, 73. Brazil, Russia, and India have life expectancies at birth of 72,68 and 64 respectively. About 83% of women in China survive to age 65 yet only 41% in South Africa reach that age. Less than 50% of males in Russia and South Africa survive to age 65, these two countries having proportions of 46% and 31% respectively. South Africa's

infant and under-five mortality rates are lower only than those of India. The latter has an under-five mortality rate of 69 per 1 000 while South Africa's rate is 67. The infant mortality rate for India stands at 52 per 1 000 live births while that of South Africa is 48. Russia has the lowest infant and under-five mortality rates at 12 and 13 respectively.

Ideally, a substantial health budget should translate to a higher life expectancy and a higher proportion of individuals surviving to age 65. Infant and under-five mortality rates would also be reasonably expected to be much lower. According to Thuthukani Ndebele, a researcher at the institute, the relatively high health expenditure in South Africa does not result in good outcomes for national health. In fact, the country's health indicators are often worse than those of countries which spend a smaller slice of GDP.

## NURSE SHORTAGE MAY RUIN NHI PLAN

LETITIA WATSON: Fin24.com, 6 February 2011

Over the next 10 years a shortage of nurses with degrees and diplomas could foil the government's plans to have nurses assume certain doctors' duties under a National Health Insurance (NHI) Scheme. According to the South African Nursing Council (SANC), it had 221 817 registered nurses on its database in 2009. Of these 111 299 had a diploma or degree in nursing (being referred to as registered nurses); 48 078 had completed

two years of training; and 62 440 had had one year of training. The SANC's register does not, however, reflect the true picture in South Africa because many nurses remain on the register although they are working overseas.

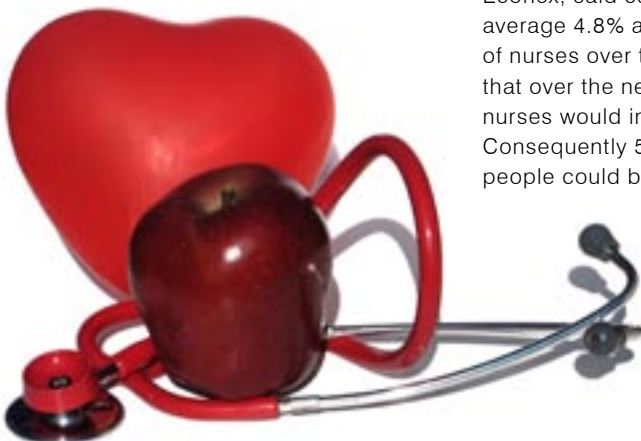
Research by the Human Sciences Research Council (HSRC) in 2009 confirmed that some kept their registration here while working overseas, with a view to returning one day. Mariné Erasmus, a senior economist at economic research company Econex, said calculations based on the average 4.8% annual increase in the number of nurses over the past five years showed that over the next decade the number of nurses would increase to 291 942 by 2020. Consequently 560 nurses for every 100 000 people could be expected by that year. This

did not compare badly with most middle-income countries, which have 400 per 100 000 people, and it looks better than the anticipated shortage of doctors in the near future.

The problem would, however, be the shortage of available registered nurses with degrees or diplomas, she said. In 2000 registered nurses comprised 54,4% of the number of active nurses in the country, but the number had declined each year to 50,2% in 2009. If this rate of decline should continue, the number would drop to 42,6% in 2015 and 37,5% by 2020.

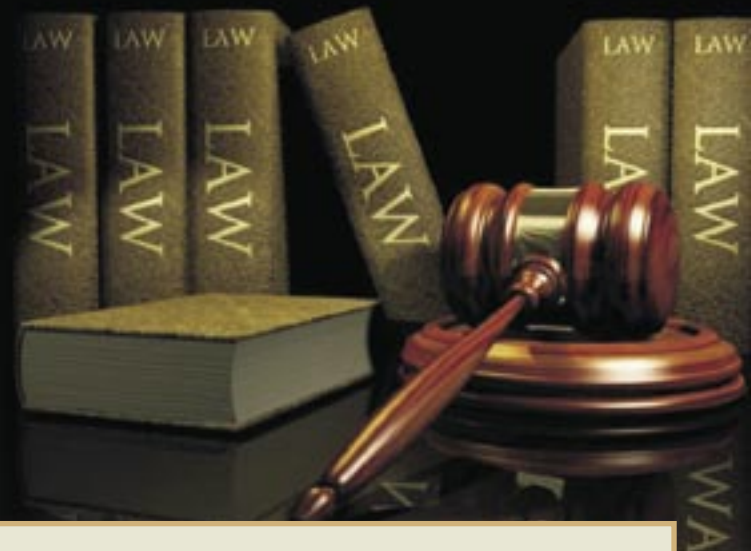
Econex research indicates that up to 50% of the registered nurses are older than 50, which means almost half of the current group could retire in 10 to 15 years' time. Out of the pool of registered nurses it is mostly registered nurses that emigrate. This sketches a sombre picture for the supply of a quality nursing service in the country in the next few years, especially against the background of government's plans to reform the healthcare industry.

The ANC's latest discussion documents on the NHI confirm government's plan for the re-assignment of duties, where nurses will increasingly have to perform doctors' services. This implies a huge need for registered nurses who would be best qualified to assume certain doctor's functions, said Erasmus.



# NATIONAL HEALTH ACT, 2003 AMENDMENT BILL

To amend the National Health Act, 2003, so as to define certain expressions and to delete certain obsolete definitions; and to provide for the establishment of the Office of Health Standards Compliance; and to provide for matters connected therewith. Be it enacted by the Parliament of the Republic of the Republic of South Africa, as follows:



## AMENDMENT OF SECTION 1 OF ACT 61 OF 2003

1. Section 1 of the National Health Act, 2003 (hereinafter referred to as **“the principal Act”**), is hereby amended-
  - (a) by the deletion of the definition of **“health officer”**;
  - (b) by the insertion after the definition of **“hospital”** of the following definition: **“inspector’** means an inspector appointed in terms of section 81C;”;
  - (c) by the deletion of the definition of **“Inspectorate for Health Establishments”**;
  - (d) by the insertion after the definition of **“norm”** of the following definition: **“Office of Health Standards Compliance”** means the office established in terms of section 77 (1);”;
  - (e) By the deletion of the definition of **“Office of Standards Compliance”**.

## REPEAL OF SECTION 18 OF ACT 61 OF 2003

2. Section 18 of the principal Act is hereby repealed.

## AMENDMENT OF SECTION 36 OF ACT 61 TO 2003

3. Section 36 of the principal Act is hereby amended by the substitution in subsection (6) for paragraph (a) of the following:
  - (a) **“On the [recommendations of ] information received from the Office of Health Standards Compliance in terms of section [79(9)(b)] 81A(6);”.**

## REPEAL OF SECTION 47 OF ACT 61 OF 2003

4. Section 47 of the principal Act is hereby repealed.

## SUBSTITUTION OF CHAPTER 10 OF ACT 61 TO 2003

5. The substitution for Chapter 10 of the principal Act is described below.

## CHAPTER 10: OFFICE OF HEALTH STANDARDS COMPLIANCE

### ESTABLISHMENT OF OFFICE OF HEALTH STANDARDS COMPLIANCE, ITS OBJECTS AND INDEPENDENCE

77. (1) The Office of Health Standards Compliance (in this Chapter referred to as the Office) is hereby established as an organ of state at the national sphere of government and is headed by and under the control of an Executive appointed in terms of section 81 (1).
- (2) The objects of the Office is to-
  - (a) ensure that complaints from health care users are investigated properly and dealt with expeditiously through an independent mechanism; and
  - (b) facilitate compliance by health care providers, health establishments, health facilities and health with the norms and standards for the national system.
- (3) No person may in any way interfere with, hinder or obstruct any member of the Office in the performance of his or her functions.
- (4) Any person who contravenes or fails to comply with subsection (4) is guilty of an offence.
- (5) All organs of state must accord such assistance as may be reasonable required for the effectiveness of the Office in the performance of its functions.

### FUNCTIONS OF OFFICE

78. (1) The Office must-
  - (a) advise the Minister on the development of norms and standards for the national health system and the review of such norms and standards;
  - (b) certify health establishments as compliant with prescribed norms and standards;
  - (c) ensure compliance with prescribed norms and standards by health establishments;
  - (d) investigate complaints relating to the health system;
  - (e) monitor indicators of risk as an early warning system relating to serious breaches of standards; and
  - (f) exercise and perform other functions and powers conferred upon it by this Act.
- (2) The Minister exercises final responsibility over the Office.
- (3) To enable the Minister to exercise his or her final responsibility in terms of subsection (2), the Executive Director of the Office must, at the request of the Minister-
  - (a) furnish him or her with information or a report with regard to any case, matter or subject dealt with by the Executive Director, an inspector or any other employee of the Office in the performance of his or her functions; and
  - (b) provide him or her with reasons for any decision taken by the Executive Director, an inspector or any other employee of the Office in the performance of his or her functions.

(CONTINUED ON PAGE 10)

**NATIONAL HEALTH ACT,  
2003 AMMENDMENT BILL**

(CONTINUED FROM PAGE 9)



**ROUTINE INSPECTIONS**

82. (1) **[A health officer]** An inspector may enter any premises, excluding a private dwelling, at any reasonable time and-
- (a) inspect such premises in order to ensure compliance with this Act;
  - (b) question any person who he or she believes may have information relevant to the inspection;
  - (c) require the person in charge of such premises to produce, for inspection or for the purpose of obtaining copies or extracts thereof or therefrom, any document that such person is required to maintain in terms of any law; and
  - (d) take samples of any substance that is relevant to the inspection.
- (2) **[A health officer]** An inspector may be accompanied by an interpreter and any other person reasonably required to assist him or her in conducting the inspection.
- (3) **[A health officer]** An inspector may issue a compliance notice to the person in charge of the premises if a provision of this Act has not been complied with.
- (4) A compliance notice remains in force until the relevant provision of the Act has been complied with and the **[A health officer]** inspector has issued a compliance certificate in respect of that notice.
- (5) **[A health officer]** An inspector who removes any item other than that contemplated in subsection (1) (d) must-
- (a) issue a receipt for it to the person in charge of the premises; and appeal with the [head of the relevant provincial department] Executive Director.

**ENTRY AND SEARCH OF PREMISES WITH WARRANT**

- 84 (1) [A health officer] An inspector accompanied by a police official may, on the authority of a warrant issued in terms of subsection (5) and subject to section 86, enter any premises specified in the warrant, including a private dwelling, and-
- (a) inspect, photograph, copy, test and examine any document, record, object or material, or cause it to be inspected, photographed, copied, tested and examined;
  - (b) seize any document, record, object or material if he

- or she has reason to suspect that it might be used as evidence in a criminal trial; and
  - (c) examine any activity, operation or process carried out on the premises.
- (2) [A health officer] An inspector who removes anything from the premises being searched must-
- (a) issue a receipt for it to the owner or person in control of the premises; and
  - (b) unless it is an item prohibited in terms of this Act, return it as soon as practicable after achieving the purpose for which it was removed.
- (3) Upon the request of [a health officer] an inspector acting in terms of a warrant issued in terms of subsection (5), the occupant and any other person present on the premises must-
- (b) on request of the person in charge of such premises, show his or her certificate of appointment as [a health officer] inspector to that person.
- (4) [A health officer] An inspector or police official contemplated in subsection (1) may overcome resistance to the entry and search by using such force as is reasonably required, including the breaking of a door or window of the premises.
- (5) Before using force, the [health officer] inspector or police official must audibly demand admission and must announce the purpose of the entry, unless there are reasonable grounds to believe that doing so might defeat the purpose of the search.

**ENTRY AND SEARCH OF PREMISES WITHOUT WARRANT**

86. [A health officer] An inspector accompanied by a police official may without a warrant exercise any power referred to in section 84 (1) if-
- (a) the person who is competent to do so consents to such exercise; or
  - (b) there are reasonable grounds to believe that a warrant would be issued in terms of section 84 (5) and that the delay in obtaining the warrant would defeat the object of the warrant.

**DISPOSAL OF ITEMS SEIZED BY [HEALTH OFFICER] INSPECTOR**

87. (1) The [health officer] inspector must deliver anything seized in terms of section 84 or 86 without delay to a police official contemplated in section 30 of the Criminal Procedure Act, 1977 (Act No. 51 of

**(UN)HEALTHY**



“The only way to keep your health is to eat what you don’t want, drink what you don’t like, and do what you’d rather not.” ~ *Mark Twain: American Humorist, Writer and Lecturer. 1835-1910.*

“Every human being is the author of his own health or disease.” ~ *Hindu Prince Gautama Siddharta, the founder of Buddhism, 563-483 B.C.*

“So many people spend their health gaining wealth, and then have to spend their wealth to regain their health.” ~ *A. J. Reb Materi.*

“The patient should be made to understand that he or she must take charge of his own life. Don’t take your body to the doctor as if he were a repair shop.” ~ *Quentin Regestein*

“He who takes medicine and neglects to diet, wastes the skill of his doctors.” ~ *Chinese Proverb.*

“Red meat is not bad for you. Now, blue-green meat, that’s bad for you!” ~ *Tommy Smothers*



### THE AXED BONITAS BOARD OF TRUSTEES

and acting principal officer, Gerhard van Emmenis, have filed a court application seeking to be re-vested with their powers and functions, according to Council for Medical Schemes (CMS). Two months ago, the CMS went to court for an order divesting Van Emmenis of the powers and functions of the board and instead placing them with independent persons. The board was removed last year as it was found not to be fit and proper. The governance of Bonitas now rests with Joseph Maluleke, a compliance officer. Van Emmenis and the axed board also want a court order declaring that he and the Bonitas medical fund do not have to comply with the terms of the court order issued five months ago, which divested them of their powers and directed that Van Emmenis should ensure that a new board was elected. In a statement issued yesterday, the CMS said it would soon take a decision on the fitness of some of the trustees.

*Ayanda Mdluli: Business Report, 4 February 2011*

### UNIFORM TARIFFS ON VARYING

treatment procedures for patients across the country may be introduced following moves by the SA Medical Association (Sama) to standardise billing codes. Sama has asked the Competition Commission for an exemption to allow it to discuss the proposed standardisation, the organisation's chairman, Norman Mabasa, said at the conclusion of a meeting with the commission at which talks centred on the Doctors' Billing Manual, a book that guides doctors' billing codes. Mabasa said the book was outlawed in 2004 and it meant there was confusion over what doctors charged for treatment plans. He said that by allowing it to be published again, there would be clear codes and standardised tariffs. If exemption is granted for the tariffs it would imply that there will be certainty about how much a consultation will cost, depending on the category of the practitioner. If exempted, doctors and funders will be able to discuss the codes and the rand value. Oupa Bodibe, the manager for advocacy and stakeholder relations at the Competition Commission, confirmed the meeting, saying it was agreed that Sama would submit a request for an advisory opinion on the billing manual. This, he said, was a non-binding advice from the commission on how it would approach a matter that was likely to be anti-competitive. At present, there is no benchmark for prices following last year's court decision that set aside the government's reference price list. Schemes have their own rates for the various procedures and in some cases patients have to pay the shortfall if what the service provider has billed for is above the scheme's rate. The schemes are by law expected to pay in full for prescribed minimum benefits which consist of close

to 300 conditions. However, this is also being contested by the funders. Bodibe conceded that competition in the healthcare industry had not been enhanced as a result of the law that prohibits competitors from discussing prices, which is regarded as price fixing. He said the commission did appreciate that healthcare had particular dimensions that were peculiar to it. He said government regulation was needed, and the commission accepted that healthcare could not work on a free market basis. The Minister of Health, Aaron Motsoaledi, is also trying to create a platform for healthcare providers to sit together and negotiate prices and he has also approached the Competition Commission. Motsoaledi wants to set up an independent pricing authority, which is expected to be in place in two years' time. Mabasa said Sama's application was meant to complement Motsoaledi's efforts. The Competition Commission reportedly said that it would take a decision on the matter in the next three weeks.

*Slindile Khanyile: Business Report, 4 February 2011*

### LIBERTY GROUP, PART OF LIBERTY

Holdings, has denied allegations of misappropriation, fraud or corruption on the part of one of its associated companies, V-Med Administrators. Liberty Medical Scheme (LMS) earlier confirmed that it has laid criminal charges against V-Med Administrators' managing director Patrick Masobe, ex Registrar of Medical Schemes, for alleged fraud, alternatively misappropriation of funds, alternatively theft of funds. Christine Kinsman, vice chairperson, trustee and member of LMS, said there was a fiduciary duty to report conduct of this nature and the board of trustees could not, under any circumstances, endorse misappropriation of funds. She said the unlawful withdrawal of more than R11m from LMS' accounts constituted a criminal action perpetrated against the scheme's members. Liberty Group spokesperson, Mandy Denton, denied all allegations, saying the matter referred to by Christine Kinsman involved a contractual dispute between Liberty Medical Scheme and the administrator, V-Med, adding that the contractual dispute would follow its normal course through an arbitration process in terms of the contracts. Although V-Med is mandated to effect authorised transactions based on valid instruction, or within operating mandates from the LMS bank account, V-Med's officers were specifically and legally instructed not to make payment for transfers relating to certain fees, according to Kinsman. She said V-Med's officers however apparently ignored this written instruction, and in contravention thereof proceeded to effect withdrawals from LMS' bank accounts which amounted to fraud, alternatively unlawful misappropriation,

or alternatively theft of LMS funds. Three withdrawals of more than R3m were made since November last year. Despite attempts from LMS to obtain information from V-Med regarding the withdrawals and transfers, V-Med had failed to provide any details or meaningful explanation, LMS said. Kinsman said the board's determination to recover these amounts in line with sound business practices, was aimed at ensuring that this incident would have no material impact on LMS.

*I-Net Bridge via Finn24.com, 4 February 2011*

### NORTH WEST MEC FOR HEALTH,

Dr Magome Masike, has urged health professionals to work closely with government to build strong partnerships to ensure rural communities have adequate access to healthcare services. He emphasised the importance of primary healthcare being made available to rural communities. He said doctors were needed at hospital level and in tertiary institutions, but that doctors' support to primary healthcare was equally critical if government were to effectively strengthen this level of healthcare. Masike said the health sector's contribution to rural development was to provide the best possible quality healthcare services, to develop health infrastructure and to make sure there were adequate health resources in rural areas. The MEC said the objective of rural development was a shared vision of National Health Insurance (NHI) which sought to provide access to quality healthcare services to poorer communities. He said it was important that doctors understood NHI in this context.

*The Citizen: 16 February 2011*

### A SYNDICATE OF BOGUS DOCTORS

operating across the country appears to have far more members than originally believed. The discovery that up to 17 "doctors" could be part of a syndicate comes as the Board of Health Care Funders starts its own probe into their activities. The syndicate, whose members were all allegedly operating with the same practice number, was bust last week when Hawks detectives raided practices across South Africa. BHF spokeswoman, Heidi Kruger, said that initial investigation showed that 17 doctors' credentials had been called into question. Stopping short of calling the group a syndicate, Kruger said they were made aware of the doctors after media reports about the arrests. She said that with the help of the police the BHF was now investigating how many of doctors were out there operating with the same practice number. She said that so far, there were definitely more than seven doctors - the number being in the region of 17.

*Graeme Hosken: The Cape Argus, 15 February 2011*

**THE MINISTERIAL ADVISORY COMMITTEE**

on National Health Insurance (NHI) has finalised a policy document that will shortly be submitted to the Cabinet, according to Health Minister Aaron Motsoaledi. The African National Congress views the NHI as a measure to close the gap between the quality of healthcare available to rich and poor in SA. The party released its own policy on the NHI last September, which was developed in a separate process to that devised by the advisory committee, chaired by Human Sciences Research Council CEO Olive Shisana. Dr Motsoaledi's spokesman, Fidel Hadebe, said the NHI policy would be submitted to the Cabinet "as soon as its programme permits, but it will be soon". Once approved by the Cabinet, the policy will be released for public comment as a white paper. Interested parties will have three months to comment. It will then go back to the Cabinet, before being submitted to parliament to be brought into law. No timelines were given. Briefing reporters in Parliament, Dr Motsoaledi said the Ministerial Advisory Committee drew up its first draft of an NHI policy a year ago, but was asked by the Cabinet to do more

work on primary healthcare, the cost of the NHI, and its economic benefits. He said the Department of Health had also been hard at work during the past year, auditing health institutions, staff and equipment in preparation for implementing the NHI.

*SAPA, 15 February 2011*

**NEW RESEARCH SUGGESTS DEATH**

rates from cancer are likely to fall across the EU in 2011. A study published in the Annals of Oncology suggests that the actual number of Europeans who die from cancer will rise from 1 256 001 in 2007 to 1 281 466 this year. The rate of deaths per 100 000 people will fall, however, by about seven per cent in men and six per cent in women. Scientists at the University of Milan in Italy and the University of Lausanne in Switzerland used a new mathematical model to produce the estimates. They analysed cancer death trends between 1970 and 2007 and used this information to make predictions about 2011. Professor Carlo La Vecchia, from the University of Milan, said that despite these favourable

trends in cancer death rates in Europe the number of cancer deaths remained approximately stable, due to the ageing of the population. He added that there was a persisting gap in cancer mortality between Central and Eastern European countries compared with Western Europe, and this was likely to persist for the foreseeable future. The study also suggests that the number of women dying from lung cancer will increase across Europe, although the UK - which has had the highest lung cancer death rates for a decade - will see a levelling off. Mike Hobday, head of policy at Macmillan Cancer Support, said that while the overall number of people dying from cancer was predicted to fall, the number of people living with cancer in the UK was rising by three percent each year. He said that for many, cancer was now a long-term condition and it was important to realise that it was no longer just about people dying quickly of cancer or being cured. Hobday said that the NHS and medical profession needed to recognise the long-term impact of cancer and its treatment on patients so everyone got the help that was right for them.

**NURSE YOUR HEART**

**THE PLAY:** Circle

**THE THEATRE:** Market

**THE RUN:** until 20 March

**THE VERDICT:** Every winner of the Zwakala festival is worth seeing.



**D**irected by Oscar Motsikoe, Circle is a very familiar story. Young dreamers land at varsity ready to conquer the world only to be excluded due to an inability to pay a year later. Michael, aptly portrayed by budding actor Tau Maserumule, follows the triumph of a young man that had suffered the indignity of being kicked out of university. Michael's problem, nonetheless, begins when he decides to launch a protest against such recognisable financial exclusions, following a fee increase 10 times above inflation.

After being kicked out of university for organising a march, the youngster finds himself almost a vagabond. But he refuses to allow this painful incidence to bog him down and gets a job at a construction site – where he finds himself once again standing up to injustices. Trouble seems to follow him as this dreamer grapples with the vicissitudes of normal life in an abnormal society.

The graduate of the esteemed Market Theatre Laboratory, Maserumula is gifted, young and the best act of the Zwakala festival. He has worked with international directors such as Tim Flywell, Academy Award nominee Edward Zwick and, perhaps most notably, the late Academy Award winner, Anthony Minghella.

# Life is in the Details...



...introducing ISO7396-1 compliant Medical Air, Vacuum and AGS Systems.



## Surpassing International Standards...

Today's medical arena is more tightly regulated than ever. Atlas Copco's medical systems are pre-certified to simplify your certification process on installation. They surpass the requirements of the most demanding standards and regulations such as:

- Medical Device Directive MDD 93/42/EEC • European pharmacopoeia • EN ISO 7396-1 • ISO 14971
- Health Technical Memorandums HTM 02-01 and HTM 2022 • NFPA.

## Key Features...

- Individual Motor control panels allows for more user friendly access and allow you to run one unit while the other unit is being maintained for added safety
- Robust, high endurance & efficient compressors, pumps and blowers • Galvanised vessel inside and out for ultimate protection against corrosion
- Automatic sequencing of compressor/pump & rotates the lead unit to ensure even wear • Easy access to fixing points for quick and installation
- Central controllers include an event log browser for maintenance assistance • High performance filters with differential pressure gauges for indicating saturation • Clear access to serviceable components makes maintaining our systems quick and safe
  - Building Management System output for interfacing with additional monitoring systems
  - Various options available to supplement your specific requirements including SMS alerts, additional filtration, etc.



Atlas Copco South Africa (Pty) Ltd  
P O Box 14110, Witfield 1467  
Tel: (011) 821 9000, Fax: (011) 821 9106/7  
E-Mail: [air.compressors@za.atlascopco.com](mailto:air.compressors@za.atlascopco.com)  
[www.atlascopco.com](http://www.atlascopco.com)  
[www.atlascopco.co.za](http://www.atlascopco.co.za)



AD-11-101010

*Sustainable Productivity*

**Atlas Copco**

*a service with a smile....*



Louis Pasteur Medical Centre is an established healthcare facility in the heart of Pretoria and also home to the Louis Pasteur Private Hospital, rendering diverse medical and nursing services of world class standard ranging from minor one-day dental procedures to highly specialized cardio-thoracic and Neurosurgery.

The Hospital is known for its modern facilities, state of the art equipment and the comprehensive field of medical specialities, inter alia Internal Medicine, Gynaecology, Ear, Nose and throat Surgery, Cardiology, Nephrology, Rheumatology, Plastic and Construction surgery, Maxillofacial surgery, Orthopaedics, Paediatrics, Urology, Psychology, Psychiatry, Audiology, Physiotherapy, Occupational therapy as well as other supplementary health services.

This upmarket private hospital has an in-house pharmacy and casualty that are opened on a 24-hour, 7-day a week basis, thereby providing 24/7 medical support to the broader community. Its Primary Healthcare Centre specialises in family planning, Immunisation, HIV Counselling as well as minor ailments direct to the public.



This well known landmark is ideally situated in the heart beat of Pretoria CBD, on the corner of Prinsloo and Schoeman Streets, with easy access to all national roads to and from Pretoria and the surrounding areas.

Louis Pasteur Private Hospital is committed to ongoing improvement through total customer satisfaction, rendering service excellence with a smile within a safe, healthy and environmentally friendly facility.



Total Customer Satisfaction