LUH IOOQq/OOMC IO?
MY PERSONAL
HEALTH
" Making quality primary
healthcare accessible, affordable and accountable."
DR EV RAPITI
10TH OCTOBER 1992
Revised 17th October,1993

DR E. V. RAPITI MBBS;MFGP;DCH
61 Ryan Way,Mandalay.Tel 3873239/3976029 Pr N01463519
5th March,1994
Ms Cherryl Corolous
ANC Health Dept
ANC
Dear Ms Caolous,
I am indeed pleased to finally have the opportunity of meeting you to discuss your health plan and to share with you ideas of my own on the subject.
It is with great pleasure that I give you a copy of my idea of a National Health Insurance for South Africa.
My ideas have come as a result of my interest in finding an equitable healthcare system for South Africa whilst I was chairman of NAMDA in the Western Cape in 1983.
it took me ten years of following the trends all over the world to come up with a plan that would be acceptable to wide a spectrum of people, ranging from the public, the doctors and the government.
I am aware that my product needs to be fine tuned. It has its shortcomings, but these can be easily overcome.
I fully support many of the ideals of the ANC health document.However, there seems to be a problem as to how the plan would be implemented.
My product I am confident can be implemented provided that it is endorsed by the various players.
If it is at all possible, I would like to do a presentation of the product to your health desk.
Thus far the doctors, members of the public and some medical aids who have heard of it are impressed with the concept.
I am pleased to say that l have sought the opinion of Dr Anne Mills of the London School of tropical medicine and an Ex South African professor of family medicine in Oman on my product and both have given me very favourable reports on the product.
I am including two short stories that l have written for your reading pleasure.
I do hope you enjoy them.
Yours sincerely
0W3?

MY PERSONAL HEALTH
NAME :MY PERSONAL HEALTH
MPH for short and for the rest of the document the acronym MPH would refer to MY PERSONAL HEALTH.
INTRODUCTION
The concept of MPH has come about as a result of a real fear that doctors in South Africa face the possibility of either becoming bankrupt or unemployed.With the entry of big business into the healthcare scenario, the role of the doctor would be reduced to that of a mere employee of big business for the prime purpose of making huge profits for their employers.
MPH has been designed for the sole purpose of returning the role of providing care for patients to the doctor without interference from any outside 3rd party as was the case with the medical aids for the past two decades.
With the doctor in full control of his affairs it is hoped that the special doctor/patient relationship would be preserved and protected.
MPH hopes to bring down the cost of primary healthcare down to affordable levels without compromising on the standard of healthcare.
The following scheme and outline of how MPH would function, is merely in the planning stages.lt would be subjected to scrutiny of doctors interested in it before it is finally accepted.
The concept would be shared with the trade union movements, employer groups and political parties in an effort to obtain consensus before the product is launched.
a6This introduction is from the original document written on 10th October, 1992.

Revised version: 26th Septmber,1993

INTRODUCTION TO REVISED VERSION

Ever since MPH was conceived about a year ago there has been considerable activity in the healthcare scenario at home and abroad fired by the crippling cost of healthcare coupled with the morally indefensible fact that modern life saving technological innovations were becoming available only to people who could afford them and denied to people who needed them most because they lacked cash upfront to pay for these innovations.

In America, President Bill Clinton introduced a Bill in parliament to redress the gross imbalances in healthcare and to put a lid on spiralling healthcare costs. The fact that 35million Americans had no form of healthcare and that millions more would be left without healthcare cover as a result of increases in premiums by as much as 30% to 40% per annum forced President Clinton to act swiftly on the Bill.

Britain, West Germany and Sweden witnessed a breakdown in their healthcare systems as result of the global recession, steady rise in unemployment and the spiralling cost of healthcare.

Back home in South Africa political parties who were preparing for the forthcoming elections on 27th April, 1994 were too busy with negotiations and the election to give enough attention to the ailing healthcare system in South Africa.

In the absence of any direction from a government that was in its terminal stages of its forty year rule, and in the absence of any concerted attempt by the incumbent political parties to find a solution to the healthcare problem confronting the country, a number of quick fix solutions were being presented to panicking doctor groups and the vulnerable public by businessman whose main purpose for entering the healthcare platform was, it seems guided by the profitability of the healthcare industry.

The medical fraternity who should have been playing a prominent role in shaping the future of healthcare, was being marginalised by an aspirant radical element in on various healthcare platforms who grew up with an ethos that viewed the medical professionals, like all other professionals in this country as elitists rather than as people with a great deal of valuable expertise when it comes to healthcare.

Whilst this element failed to produce anything tangible other than slogans, members of the business sector jumped on the band wagon trying to sell failed American model HMO’s to doctors and the public. The doctors in turn started forming all kinds of lPA’s without giving a slightest thought to the actual workings of lPA’s in the South African context.

_____%
Many of these IPA’s were self centred without any attention to social justice. If anything, the only reason to revise or replace the South African healthcare system is because it totally ignored the healthcare needs of almost 60% - 70% of the population. This neglect has been there for well over a century but was accentuated over the last 20 years with the failed Verwodian policies of "Bantustans", where the infant mortality rate is comparable to the worst in Africa. No political party in South Africa aspiring to become the future government of this country can afford to win at the polls without addressing this very vital issue of healthcare.Mere slogans will not be enough to bring down the incidence of malnutrition, infant mortality rate or tuberculosis.

What is the ideal system?

Should South Africa opt for the National Health System of Britain or continue with the present private and state funded systems?

Private sector

The furore over the Bill to amend the present Medical Schemes Act is a clear indication that the current medical aid system is no longer viable and consequently unsuitable for this country. The public who belong to medical aids can no longer afford premiums as high as R800- R1000/ month to belong to medical aids which the providers (doctors, hospitals, pharmacists etc) have been unhappy with. The iII-timed and ill-conceived entry of the top-up insurance healthcare packages has done very little to reduce costs to the patients. The reverse has taken place. Medical aids were saddled with the aged and chronically ill whilst the insurance companies grabbed the young and healthy. The loss of the young and healthy from the medical aids destroyed the element of cross-subsidisation through which the medical aids were able to keep premiums down.

IPA’S & HMO’S DESPERATE MOVE

The attempt by doctors and the medical aid industry alike, to set up HMO’S and lPA’s are desperate moves by people in want of a solution as the heavy hand of disaster strikes a fatal blow to their survival.

Surely these people are taking no heed of the bitter experiences of America, which has an economy that is gargantuan compared to that of South Africa.

If these systems have failed in America, how can they ever work in third world South Africa?

It must be borne in mind that the IPA & HMO systems make little or no allowance for the underprivileged of this country.

STATE HEALTH SERVICES

The closure of a number of state institutions, the sale of some state hospitals to the private sector, the underfunding and understaffing of state hospitals, the decision to allow state employed doctors to run partial private practice to supplement their salaries are clear signs that the indigent, frail and chronically ill would suffer maximally if a proper system of healthcare is not found soon. It would be enough to spark off a revolution.

We simply cannot do a Marie Antoinette and say "eat cake if you have no bread" when the sick are turned away from our state institutions whilst people with the slightest of ailments are accepted because they have the money to be treated. Imagine the conflict that, that type of scenario would instill in doctors who have to treat with a conscience or would they be expected to work without one.

NATIONAL HEALTH SYSTEM, NATIONAL HEALTH INSURANCE

Ideally all countries in the world should adopt either of these systems because they espouse the values of caring that would make any citizen or country proud of. Unfortunately the cost of running these systems, no matter how superior to the American managed care systems on the score of social justice, poses as a strong wedge between reality and the ideal as evidenced by the British experience.

Britain seemed to have coped well when its economy was booming and the unemployment figures was less than ten percent. Now that the country has undergone a period of recession and the unemployment figures hovers at around 18% the NHS is Britain is on the precipitous edge of collapsing.

WHAT IS THE SITUATION IN SOUTH AFRICA

Unemployment in South Africa is about 50%. This figure would be much higher if statistics in the homelands,where the majority of the country’s indigent reside, is made available.

0f the 50% employed, about 30% if not more live around the poverty datum line, from whom collecting taxes would tantamount to strangulation.

Realistically speaking, therefore, South Africa has only about 20% - 30% who would be able to contribute to the state’s coffers by way of tax.

If Britain’s NHS is on the verge of collapse when it is funded by 80% of the employed, then what chance has this country got of funding an NHS to the standards of Britain on the taxes of 30% of its employed. The tax on the 30% would be so exorbitant, that there is bound to be a rebellion amongst the tax paying public. Such excessive funding would not be found in a democracy which espouses the virtues of free enterprise.

What would taxes from 30% buy?

The money from the taxes of 30% of the gainfully employed would be gobbled up by: state salaries, management, treatment of communicable diseases like TB, cancer and a few medical and surgical conditions. if one has to look at the British or Canadian examples where the waiting period for non urgent surgical procedures (hip replacement for example) is about 2 years, then it wouldn’t be far fetched for that waiting period to be in the region of 10- 15 years in South Africa.

One has to take into account that this dramatic drop in services would apply to people who have belonged to the medical aid system where procedures were done within a few days of the diagnosis being made.

It should not come as an alarm if these people (30% employed), accustomed to a higher standard of service than in Britain, revolted if they were to be the principle funders of a system that is comparable to the worst in Africa.

Put very plainly, the overtaxed would be getting back the equivalent of 1 cent for every rand they contribute towards the healthcare system. For the majority of unemployed and indigent, the little that this system would provide would be seen as something wonderful against the total absence of any service at all.

STRIKE A BALANCE

What would be the ideal solution is to strike a balance between the purely expansive but expensive NHS and the expensive but restrictive current Medical Aid System.

MY PERSONAL HEALTH

MPH is a hybrid variety of a State and Private NHI which combines the best of both worlds. It is inexpensive so that it would be accessible a far greater number of people than are presently covered by medical aids. The total reduction in cost of healthcare to the individual contributing to the system would mean that the individual would have more funds to cater for his/her other needs like housing and education which would impact positively on the individuals living standards.

The greater number of enrolees onto the system would reduce the state burden in terms of numbers and financing.

The fact that the providers working in the system would be available to the elderly and the chronically ill would instill a sense of dignity in these people who have for decades been subjected to the indignity of getting up very early in the morning to join never ending queues to be seen for a fraction of a second by the overloaded and underpaid state doctor.

DECREASE IN RANGE OF SERVICES

In the interest of making healthcare affordable to a great majority of the employed, the contributors to the system would have to accept a decrease in the range of services. The same kind of thinking is now being accepted in many states in America and in Canada.

The luxury of a wider range of services should be made available at a premium.lt would be upto the consumer to decide if they wish to buy these more expensive and sophisticated services.

Author’s note

The author developed this system as result of an interest to set up a primary healthcare system that is equitable and affordable. It took ten years of trailing the road of medical politics with the progressive organisations to arrive at such a solution. The seeds of interest were sown in the author’s abhorrence to the first world attitude to healthcare in this country compared to how things were done in third world India where the author gained his knowledge first hand.

This new version makes allowance for specialist, secondary and tertiary care.

MY PERSONAL HEALTH

AIM:

Provide basic health care at an elementary level at an affordable rate as well making it as accessible as possible.

BASIC HEALTHCARE

Any service obtainable in a doctor’s surgery, that would improve the general well-being of the individual would be regarded as basic healthcare.

SERVICES IN A DOCTOR’S ROOMS:

PREVENTATIVE: Immunisation

Family Planning

Screening - adults

- children

PROMOTIVE: Life Style:

Individual - physicaI/mental

Family -

Community - drugs

- environment

- stds

- divorce

- teenage prey

Sports & Sports Injuries

CURATIVE: MEDICAL & SURGICAL:

Cold

Acute

Chronic

ACUTE:

Refers to any medical or surgical calamity that could afflict a patient suddenly. The MPH doctor would assess and manage the patient to the best of his ability.

SERVICES:
The total list of services provided by the MPH doctor would be determined by the committee of general practitioners elected by the MPH doctors.
This list would be made available in a booklet form to both the doctors and patients who are members of MPH.
The list of services would be revised regularly with the view to make MPH services progressively expansive to the benefit of the patient.
Patients who are members of MPH could via their representatives request the MPH committee to incorporate any particular service.
The final decision as to whether a particular service should be excluded,removed or rejected would rest on the executive committee of MPH after it has had full discussion with representatives of the patients.
MEDICINES:
MPH doctors would work with a select list of drugs, which would be obtained for the MPH doctors at a special tender rate.
DRUGS OUTSIDE SELECT LIST:
If an MPH patient requires a drug outside the list then the MPH doctor could acquire the drug for the patient from:
(a) funds in a special kitty if his MPH practice is big enough or
(b) by charging the patient for the drug at cost plus a handling fee.
(0) via an MPH pharmacist who would be reimbursed from a special fund for that purpose.
At no time will MPH entertain the idea of an MPH doctor dispensing drugs for profit.
CONTRIBUTIONS COST NUMBER OF CONSULTATIONS
Single member R60/mth 6
Member -l- spouse R80/mth 10
Member -I- 2 dependants R100/mth 15
Member -l- 3 dependants R120/mth 20
Each additional member R15 per 3 additional consultations.
ADDITIONAL CONSULTATIONS - SPECIAL CASES:
Medical conditions requiring regular monitoring would be granted an additional six consultations, provided that these conditions do not constitute more than 20% of the total number of MPH members enroled into a particular practice.

MORE THAN 20%:
This would apply to doctors working in areas where the general patient profile(for example if the patient population is mainly geriatric) demands more than the stipulated 5 consultations/year, then the MPH doctor could double the consultations by doubling the cost.
l6This is merely a suggestion. Other ideas to resolve this problem can be considered, like an insurance risk fund.
The purpose of such a clause is to:
(a) prevent the doctor running at a loss
(b) maintain a high standard of service to the patient
CHRONIC STABLE PATIENTS:
These patients could be assessed at two monthly intervals and come for repeat prescriptions in the intervening months.
Ideally on the repeat prescription the doctor's nurse should obtain the base line reading (e.g. blood sugar or blood pressure or peak flow) for the doctor's records.
IN THE EVENT OF AN EMERGENCY:
If a patient took ill suddenly in another area or when the patient's doctor was not available, then the patient could go to any MPH doctor in the area and obtain services from that doctor. The attending doctor will bill the patient's own doctor. The fee for such a service would be decided by the MPH doctor committee.
The patient's own doctor would recoup the money by deducting one consultation from the allotted number of consultations for the patient in question.
SECOND OPINION:
If a patient chooses to have a second opinion, then the patient would have to pay 25% of the doctor's fee and the patient's own doctor would pay the remaining 75%.
The patient's own doctor would recover the cost by deducting one consultation from the remaining number of allotted consultations for that patient.
If patients wish to keep the decision of seeking a second opinion confidential, then they would have to see another doctor at their own cost.
10

DUTIES OF EMERGENCY AND SECOND OPINION DOCTOR:
MPH doctors should at all times inform the patient's doctor of their findings from an ethical point of view and to confirm that the patient has not resigned from the scheme.
RESIGNATION:
If a patient resigns from the scheme due to unemployment or for any other reason then he/she would have to forfeit one month's contributions and hand in his/her card
CHANGE TO ANOTHER MPH DOCTOR:
If a patient moves to another area then the patient could request his/her present doctor to refer the patient to an MPH doctor in the patients new area of residence.
The patient must transfer future contributions to the new MPH doctor.
The patient's own doctor would forward all relevant information about the member and his family to the patient's new doctor with the permission of the patient.
CHOOSING TWO DOCTORS:
This can be done in two ways.
The patient can choose two doctors for reasons that the family is split due to work, or divorce.
The first option is to buy membership twice.
The second option is for the two doctors to split the contributions.
In the latter case consultations will have to be split in two with each doctor offering only half the number of normal annual consultations.
OTHER SERVICES:
This would include all services at the primary healthcare level in order to make the system comprehensive. Amongst these would be: Dental, X-rays, pathologists services, clinical psychology, physiotherapy, and medical technologists.
The provider's of these services would be reimbursed on a capitation basis. Each of these providers would be paid a certain fee for each member joining the system.
The amount for these services have to be determined by the respective organisations representing these disciplines. Also to be decided by these disciplines would be the number of enrollees they would be able to cater for, per service provider.

l
For example, one physiotherapist should be able to handle the needs of about 20 doctors. At a capitation fee of R5/ member, a physiotherapist would receive about R20,000/ month. The same would apply to all the other disciplines.

PREVENTATIVE MEDICINE:

MPH patients should be entitled to:

(1) 1 Male check up annually
- full physical
- ECG
- serum cholesterol (above 30 years)

(2) 1 Female check up
- full physical
- ECG
- serum cholesterol (above 30 years)
- pap smear
- breast check up

(3) Immunisation for children
(with states assistance for vaccines)

(4) Screening tests for children.

RUNNING OF MPH:

The MPH concept can become a subsidiary of any group of medical doctors or in areas where there is no such group then participating MPH doctors can form their own group.

APPLICATION FOR MEMBERSHIP

Any doctor wishing to become an MPH doctor will have to apply to the MPH committee who will accept the application after perusal of the application.

REQUIREMENTS FOR APPLICATION:

(1) Doctor must be registered with the SAM&DC.

(2) The doctor must agree to abide by the rules and regulations set out by MPH.

(3) The doctor must have medical insurance.

RULES TO DOCTORS:

(1) Practice ethically at all times.

(2) Touting would not be tolerated.

(3) Should not exceed 500 enrollees or a maximum of 2 000 patients in the interest maintaining high standards.

(4) Cannot open a practice in the neighbourhood of an MPH doctor with an enrollee base of less than 300 members or 1 000 patients.
atThis clause will be waived for doctors already in existence prior to the launch of MPH.
(5) MPH doctors guilty of an aberration or misdemeanour would be requested to appear before the doctor’s peer review committee.
(6) MPH - reserves the right to withdraw a doctor’s contract if he/she is found to be guilty of bringing MPH into disrepute by his/her actions.
(7) Re-instatement of an MPH doctor would be left entirely in the hands of the committee and the doctor’s association.
(8) A doctor guilty of negligence regarding management of a patient will be dealt with in the usual way by the SAM&DC.
(9) MPH will merely act as facilitators in the event of a dispute. All other matters like fraud will be dealt with in a court of law.
(1 0) MPH doctors would be free to negotiate a fee for services not stipulated in the MPH guide for services offered.

RULES FOR PATIENTS:

(1) To use MPH card only for registered dependants.
(2) To avoid frequent doctor hopping.
(3) Produce a valid reason to change doctor.
(4) Refer grievances to patients’ rights committee.

PATIENT CONTRACT:

The patient would enter into a contract with the doctor of his choice. The patient could pay the administrators of MPH who will channel the money into the doctor’s account. The doctor will be kept abreast of the payments via modem into the doctor’s computer.

DOCTOR SELLS HlS/HER PRACTICE OR DEMISES:

Patients of the practice will have the right to remain in the practice or change to another MPH doctor of their choice.

CONTRIBUTION INCREASES:

The monthly contributions will be reviewed annually and increases would be linked to inflation.

FUNCTIONS OF MPH:
FARMING OUT AREAS:
MPH will farm out potential areas for doctors to set up practice and in the process prevent unnecessary over-trading.
Patient Bulletins
MPH would put out monthly bulletins on patient education and to provide a forum for doctors and patients to air their views.
REDISTRIBUTION:
MPH will assist doctors to redistribute if an area is over crowded.
MARKET CONCEPT:
MPH will market its existence to employers by advertising.
NEGOTIATE ON BEHALF OF ITS MEMBERS:
MPH will negotiate rates for its members with:
(a) specialists
(b) paramedical disciplines.
MPH will pass on benefits to its members by its power to bulk buy anything its members would require by way of equipment to enhance its members' services.
OUT PATIENT DAY PROCEDURES:
MPH - would negotiate with local authorities to permit MPH doctors to use the state's facilities for minor surgical procedures at a fee that would be within reach of the patient.
In return for the use of STATE facilities, an MPH doctor could offer to:
(1) do a session at the state hospital or
(2) offer to see unemployed chronic and pensioners at a reduced fee.
HOUSE VISITS
House visits will be charged by deducting two consultations plus an additional fee which the patient will have pay for.The amount for the additional fee will differ for a Day Visit and a Night Visit.The fee for this service will be determined by MPH in conjunction with the doctors' associations.
The reason for levying a fee for house visits is to reduce the abuse of this type of service.

ILLUSTRATION OF AN MPH PRACTICE WITH 400 MEMBERS
Total number of enrollees : 1600
Total number of standard consultations 8000
Number of cons for 320 chronic pts 320x6 1920
Grand Total 9920
Number of consultations/month 826
Number of consultations/day working 20days/mth 41
Working 7 Hours/day
Average time per consultation 10minutes
The above has been calculated on the basis that:
a6The doctor works 7 hours/day
asls off on Sundays and public holidays
a6Has one half day in the week
a6Works a half day on Saturday
The above calculation assumes that patients utilise every consultation which is unlikely because patients would be discouraged from attending a doctor to merely obtain pills.
WORKING BASE CAPITAL 4OOX R120/mth R48,000.00
DRUGS R8000.00
DRUGS NOT ON THE SELECT LIST R2000.00
Amount left for running of practice &
Income for doctor R38,000.00
STAFF
It would be advisable for MPH doctors to employ two staff nurses and two receptionists on half day basis.

ADDITIONAL INCOME

The above does not take into account sources of income from seeing patients other than MPH members.

The danger that could arise is that MPH members could suffer from under servicing because of the additional load to the doctor.

PATIENT RIGHTS COMMITTEE

One way to ensure that the quality of care to MPH patients is maintained at a high standard is to have comment cards and complaint cards for patients to fill and post to the MPH committee and to the patient's representatives.

The fact that patients would have access to air their views should act as a serious deterrent to MPH doctors to prevent their standards from dropping.

Another possibility is for an MPH doctor to have his own services rated by handing out cards for patients to fill in.

The format of the assessment card would be prepared by the MPH committee.

MATERNITY BENEFITS

The cost of ante natal care could charged as a separate item at a fee set aside by the doctor's committee and MPH. The doctor could charge a set fee of about three hundred Rands for antenatal care. This should include two ultra sounds, routine investigations in addition to the prescribed antenatal visits.

The delivery can be done by the state mid- wives or by the doctor. The cost of the doctor's services can be paid by the specialist fund.

OTHER ENVISAGED FUNCTIONS OF AN MPH DOCTOR

An MPH doctor would address members of his/her community in the local town hall or school halls on topical health issues on a two monthly intervals so as keep the doctor in close touch with the community they work in.

WHERE WOULD MPH WORK

It is obvious from the above that MPH would work best in ares where the employment rate is high, for example in the urban and peri-urban areas.

In the rural areas where a large section of the indigent reside, the country will have to optimise the use of primary healthcare sisters and upgrade the existing clinic facilities.

The MPH system could slowly be introduced into the rural areas as these areas become industrialised and employment opportunities improve.

Doctors and the members of the other disciplines who are used to a city lifestyle could be encouraged to work in the rural areas by being offered a better remuneration, housing, recreational facilities etc.

The growth of MPH will depend on the economic growth of the country.

CONCLUSION FOR PRIMARY HEATHCARE

It is fully accepted by the author that there might be many areas that have been inadvertently overlooked due to lack of foresight.This can easily be rectified by the input from the interested parties or people.

Without adequate participation by the people, at grass roots level, the project would lack the element of acceptability for it to be fully workable.

SPECIALIST COVER

Specialist cover could be bought as an add on to the primary healthcare package. The contribution for this cover would be in the region of R75-R100/ month for a family of four. The fund will be run as a National Specialist Fund. The specialists would be paid on a fee for service basis. The tariffs would be determined by the different specialities who would also form their own peer review committee. Specialists could do their operations in state hospitals but would be reimbursed for their services by the specialist fund. The state would carry the cost of hospitalisation from the state health fund.

General practitioners could also be paid from the specialist fund for work done at a secondary level.

HOSPITAL FUND

In addition to the specialist fund, a national hospital fund could be set up for the ten most common but relatively inexpensive procedures. The contribution for this should be in the region of R75-R100/mth for a family of four. In some instances the state hospitals could paid for services rendered from this fund.

HIGH RISK EXPENSIVE PROCEDURES

By pass operations, hip replacements, mastectomy could be covered by an additional high risk insurance for about R60/month per member or R90.00/mth for husband and wife.

These procedures should be done in the state hospitals in an effort to retain the high standards in our academic hospitals. The doctors doing the work should be adequately remunerated so as to prevent them from running into the private sector. Any profits generated by this system should be pushed back into the state hospitals so that there would be enough funds to offer these complicated procedures to the indigent as well.

STATE HEALTH TAX

The state should have a health tax which would cover the expenses of setting up and running the hospitals. The state should embark on a scheme to set up a number of small peripheral hospitals within the neighbourhood of the communities. The teaching hospitals should be reserved for complicated cases that cannot be handled by the smaller referring hospitals.

SUBSTANCE ABUSE TAX

Cigarettes and alcohol should be taxed to contribute towards the cost of setting up the state hospitals.

MVA

The cost of treating these conditions should come from an efficiently run MVA fund. At present these costs are either covered by Medical Aids or by the general health tax. The expenses for injuries caused by MVA should settled with the minimum of delay as is the case of injuries on duty.

STATE OUT PATIENT DEPARTMENTS ,

These institutions would play a role in providing care for the indigent with acute or minor illnesses.

These institutions would be of great value in the rural ares where the number of employed people would be too few for a doctor to build up a suitable clientele who would be able to afford MPH.

CONCLUSION

Whilst much ground has been covered in this document, the author recognises the fact that the system would have to be scrutinised carefully by all the players before it could be launched.

Learn From your past Feb,1994

Club Mykonos, Langebaan, it seems was the right place to be over the festive season. I was one of the hundreds of holidaymakers attending the M-Net/RCI summer festival. The day was scorching hot and so was the music. Two thousand watts of Rap, Rock, and Heavy Metal enveloped the man made amphitheatre.

Slender, shapely curvaceous females and bronzed muscular males were competing on stage for the Miss Bikini and Mr Beach Boy titles.

Their agility and foot work was enough to knock the socks of the Divas of aerobics.

They danced with the animated exuberance of a Zulu lmpi doing the war dance before he sets out for battle.

After about four hours, the winners were chosen. The contestants, all looked so lovely that it was difficult to say if the right person won the prize.

For me the music was getting too jarring for my taut nerves. It was more like raucous cacophony. It was really not the type of holiday I had come for.

The next day I set out for the beach in search for some peace and tranquillity.

After walking about fifteen minutes, the famous resort receded into the background like a picture in a holiday brochure, luring the viewer to come closer.

I went ahead, walking over rocks with awkward beach sandals. It was more like an exercise in stilt walking. Forty odd minutes later I reached a small patch of clean crushed shell beach amidst the rocks and shrubs. it was nature at its best. Unspoilt by man and his mortar.

Behind me stood an old wreck with a big hole on its side revealing its twisted entrails of steel and rusted iron.

I lay on the beach, hypnotised by the sonorous sounds of the orchestra of the ocean as the waves gently crushed into the rocks wondering as to how the ship landed there.

My very imaginative mind turned to a stormy night in the late eighteenth century. A ship laden with valuable cargo of silk, precious stones and spices was returning from the far east.

Unfortunately the ship, its valuable cargo and its inmates were torn asunder when it sailed head-on into the merciless Cape of Storms.

The ship was ripped apart, its valuable cargo had become valueless jetsam. Its sturdy sailors had become helpless souls crying to be with their loved ones at home far away.

I turned around and saw the ship stuck into the ground, slowly decaying.
lsuddenly reflected upon my own life in May 1993 when my ship of high ambition had met its albatross. It was crashed to the ground and its valuable cargo of ambition was thrown overboard when it met with the full fierce fury of human envy.
For the next seven months my ship of ambition had not moved an inch like the wreck behind me. I compared a human wreck to a ship wreck.
A ship wreck invites curiosity. A human wreck invites sympathy and self pity. The mere thought of being pitied was too ugly for me to contemplate.
From that moment on I decided I must put back my ship of great ambition to sea.
As I gazed into the pale blue cavernous sky, I saw the following words inscribed in bold before me:
" waste not your energy on the stagnant past;
for it would sap you of your strength
use it to shape your future.
A carefully shaped future,
would one day become a past to be proud of".
Leave the past for historians to record.
Records from which visionaries can plan the future,
You are not an historian, you are a visionary wasting
precious moments of your life.
I walked back to my Kaliva as if on air with these words firmly imprinted in my mind.
A week after returning from my holiday I was requested by the National group of doctors to present my product at a conference in Sun City. A short while later I was contacted by the major medical aid representatives about my product. It was hailed as brilliant with an invitation to discuss development of the product.
Apart from setting my ship to sail at full speed, it is hurtling towards its desired goal.
Anyone who has suffered any misfortune or injustice in the past should heed the advice in these words:
dwelling in one’s past, emaciates morally, physically and spiritually; while learning from one’s past can only enhance one’s future in every way possible".
Robert Rapiti

5th March,1994
Bread to cost R20/loaf in 2000. Why?
Do you remember the days when nutties cost four a penny. Yes I am sure you all remember. Those were the good old days when the simple pleasures in life remained the same price. That hateful word inflation never existed.
The other day I accompanied my son to the shop to learn that a nutty half the size of the ones in my days costed five cents. I gasped, exclaiming to my son that when I was a child I could buy whole pocketful which would have lasted me a week.
As we walked home I thought about how we landed ourselves into such a situation.
I believe the story goes as follows. Nutties was made by a family in England. They were not extremely wealthy but were pretty comfortable. The business expanded and so did the family. The father of the family was quite prepared to stay without when times were tough rather than increase prices and make little boys and girls miserable.
Shortly after the father died, the sons took over. They were not content with measly profits. They wanted more, so prices went up. The demand for the toffies grew as well. One of the sons who became an accountant realised that he could make a killing with the sweet. The poor innocent children had to pay the bitter price for the profit.
He listed the family business on the stock market. Anybody wanting to make a quick return bought shares in the company.
The directors did not care so much about little boys and girls like their father did. They were concerned about making huge profits for their share holders. So much for family tradition and good old fashioned family values like caring for your fellow humanbeing.
From then on prices went up regularly each year without a whimper from the children or their parents. What could the parents do when their little ones wanted a little happiness-- a penny here or there wouldn’t harm the little boy the mommies would add when dads complained about the rise in prices.
A new nutties factory opened in competition with the existing one. Prices took a tumble. Profits in the nutties factory were not to share holders liking so they decided complain bitterly that the sweets were turning their investments sour. They threatened to sell their shares.
Suddenly, out of desperation, the nutties company offer their competitor an offer they could not refuse. The old Nutties factory came back with a vengence when they formed a merger.

They now had the monoply. To keep prices down and profits high, they got rid of some of their staff- like our very own Checkers/Shoprite merger which resulted in a loss of thousand jobs.
It is a flagrant lie when companies say that they have to increase prices each year because wages have to go up ten percent. Prices have to go up if the share value the company has to increase.
The increase in worker wages hardly ever compares with the increase in the price of the product.
In 1971 one could buy a brand new Mini for fourteen hundred rand. Today about twenty five years later, with the same amount of money, one can only buy a decent racer or a very good pair of jogging shoes.
Have you noticed that in the past ten years that even though your wage has gone up ten times, your money buys you much less than it used to. You can no longer afford to spoil yourself on new clothes or a much needed holiday.
The reality that money today can buy less than it used to is a curse called inflation which modern man and woman have to live with.
This curse called inflation was thrust upon the ordinary man and woman in the street ever since caring family businesses were listed on the stock market and owned by the public.
Even essential services like hospitals and drugs listed on the stock market have wound their way up on that spiral of profitabilty. They are no longer a service for the ill but have become a commodity for the super rich.
So when bread goes up to R20/ a loaf by the year 2000, remember it is purely because the shareholders on the stockmarket want a bigger slice of your money than they would have you believe!
Robert Rapiti
Tel 3873239/7619455