aspects of the patient, because in order to be functional, one has to restore the physical ability of the patient to its fullest extent.

However, mental ability of the patients was also considered important. Physiotherapists seem to realise that the mental ability of the patient is one of the most critical aspects of successful rehabilitation, as it will have an effect on the physical outcome.

It was interesting to note that although improved quality of life was thought to be an important aspect of rehabilitation, maximum independence was rated higher.

Patients' responsibility for their own health was not regarded as very important. However, if it is felt that in order to be rehabilitated successfully, the patient should become responsible for himself, then patient education would play a vital role. Only three respondents mentioned the term "education" in their definition of rehabilitation. This was the greatest weakness the authors identified in the physiotherapists' definition of rehabilitation. The vocational potential of a patient was ranked by physiotherapists as the second least important. This finding is one that is shared by Roy et al (1988) who believe that vocational rehabilitation is not a primary aim of rehabilitation and if patients wish to return to work, this decision will be influenced more by social factors and less by medical rehabilitation.

The social potential of a patient was considered reasonably important in the definition, but physiotherapists ranked it as less important for successful rehabilitation, than physical or mental ability (Table 1).

When asked who was in charge of rehabilitation in the units where they were working, 82.3% stated that the physiotherapists were. It was felt by 39.6% of respondents that the physiotherapists where they were working, 82.3% stated that the physiotherapists should be in charge (Figure 2). Lehman (1982) was of the opinion however, that the doctor should be in control because the problem usually began with a medical condition which would determine what could or could not be done for the patient.

He also stressed that a team required a good working relationship of all health professionals involved in rehabilitation care of patients on a day to day basis with a complete understanding of the potential contribution of each member. This opinion is consistent with views expressed by Soric et al and Chamberlain.

Physiotherapists felt that they and the patient were the most essential members of the rehabilitation team (99%) but unfortunately 97% regarded the family of the patient as not important at all. According to Soric et al (1985), a family that is supportive will markedly influence the final outcome of treatment. This is consistent with the WHO's view, which confirms that the patients, their families and the communities in which they live should be part of the rehabilitation process. This would greatly enhance the patient's quality of life.

### PANEL DISCUSSION

**PHYSIOTHERAPY IN THE FUTURE - CAN WE MAKE A CHANGE?**

Although the question was not answered and the time allowed for audience participation was really not enough (perhaps we were all tired by the evening of the fourth day!) the panel discussion, dubbed "role or dole" by the congress committee, gave plenty of food for thought.

Professor Bruce Sparks, of the department of community medicine, who also chaired the discussion, outlined the problems to be faced in the next few years - those of political and economic uncertainty, mass unemployment and poverty, increasing violence and conflict, collapse of family structures, de-racialisation and loss of privileged position for minority groups. Against this background we shall also have to cope with a society in which first the youth and then the elderly predominate, and with a predicted

When one considers successful rehabilitation in terms of improved quality of life and an acceptance by the patient of self-responsibility, then the South African physiotherapists do not have a clear understanding of rehabilitation. Without patient education, the patients cannot become responsible for himself and this aspect of rehabilitation was rated very low by the physiotherapists. The concept of self-responsibility in rehabilitation has been described by many authors. Brandan (1985) states that the patient should be involved in his own rehabilitation programme as a "co-manager". The importance of self-responsibility is further stressed by Langer and Rodin who state that "persons who are given greater personal responsibility and choice in life activities demonstrate higher levels of alertness and more active participation" in their rehabilitation programme.

The authors would like to stress the point again: that for a patient to be self-responsible he has to be educated about his disease.

Physiotherapists responding to this questionnaire show little appreciation of the importance of education as well as the role of the family and the community in the successful rehabilitation of a patient. It is interesting to note that although they have a limited and superficial knowledge of rehabilitation they feel that they should be and are the most important members of the rehabilitation team.

In view of the results of the questionnaire and the fact that rehabilitation was so poorly defined, the authors conclude that the questions posed by Davids can not be answered meaningfully.

6,000,000 infected by AIDS by the year 2010, most of these in the income generating age-group.

The challenges facing South Africa include:

- defining a new South African vision
- achieving transition without polarisation
- generating fertile opportunities for collaboration
- encouraging economic growth
- restructuring education, health and welfare services
- integrating the "marginalised" youth of the country
- tackling peri-urban and slum problems
- planning for rural change and land reforms
- maintaining justice and developing an acceptable policing system

The health challenges to be faced are directly related to the above. Health costs are rising steeply at a time when the development of health services, especially preventative care, is needed

Continued on page 52.
Every physiotherapist knows that effective clearance of the bronchial passages is virtually impossible without the help of their staunchest ally - the cilia. But ciliary activity is inhibited by the thick tenacious mucus associated with bronchial disease. And, to make matters worse, the microbes associated with bacterial and viral infections can release certain compounds which slow ciliary beating\(^{(1)}\).

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urgent in rural and peri-urban areas. The development of inner city slums, family psychosocial problems, increasing numbers of young and old people and AIDS-related problems are mounting pressure on already inadequate services, and this at a time when society in general, facing increasing poverty, is making pressing demands for health and welfare services.

The health care sector has to meet the challenge of providing accessible, affordable, acceptable, effective and equitable health care. We are going to have to make decisions on the most appropriate health care personnel to provide these services, on essential, minimal drug lists and even on non-eligibility for health care. For the immediate future we are faced with the problem of providing adequate primary health care without the right personnel.

We shall have to involve communities in planning and accepting increased responsibility for health care, we shall have to provide more appropriate training of health care personnel and we shall have to decide on the management role of local authorities and of the primary health care doctor. Appropriate strategies will have to be developed to deal with AIDS, the aged and the poor.

Ways must be found to counter the lure of private practice and to accommodate private practitioners in new health services.

Costs will have to be contained and this will involve cost awareness, quality assurance and auditing programmes.

Professor Sparkes stressed the role of professional organisations such as our own in defining roles and developing strategies. We should be agents for positive change in the provision of health services and must be involved in policy-making, setting and maintaining standards, education, designing management protocols and in appropriate research. As far as educational programmes are concerned, we must match what we teach to the reality which the students will face.

Dr David Green (MASA policy division, Executive Director of NAMDA) addressed the financial issues involved. He pointed out that to treat actively the predicted number of AIDS patients in the year 2000 would wipe out the entire health budget. It is obvious that priorities will have to be determined, and it is already known that the main thrust of health services will be into primary health care. A further priority will be that of training staff - 148 clinics built in 1992 stand empty and unused due to lack of staff. He postulated that public hospitals and clinics may be transferred to a Department of Public Works, and that the Department of Health might choose to buy services instead of providing them.

At present resources in the private sector are being used inappropriately, with too many visits to doctors and specialists, too many specialised tests ordered and too many prescriptions issued. The Medical Schemes Amendment Act, which will be implemented towards the end of this year, will change this situation drastically. Under this Act medical schemes will be able to withhold payment from providers if they feel the service provided was unjustified. These providers include physiotherapists, who up to now have been protected under the Act. The Act provides incentive for the formation of health management schemes and group practices, and by January 1994 financiers of health services will be able to pick “preferred providers” - those who provide the most cost-effective services.

As far as health management schemes and group practices are concerned, budgeting policy may well give incentive not to include physiotherapists on their staff or even to buy their services! Some balances will be necessary in order to ensure that patients receive necessary treatment, but physiotherapists will have to market the necessity for their services. The changes in the advertising rules, to be gazetted shortly, will allow us to do this. Although it is unlikely that the supply of physiotherapists will exceed the country’s demand, we shall have to accept change. It may be necessary to re-locate or to change from independent private practice to working with a group practice or HMO. Above all, physiotherapists will have to learn to work cost-effectively.

Professor Bowerbank, Physiotherapy Department, University of Cape Town, took the theme of the congress - Future Shock - as the opening point for her contribution. She pointed out that shock was followed by a period of incapacity caused by successive denial, blame, self-blame and uncertainty. Action is needed now to avoid this dip in performance and to embark already on problem-solving for the future.

She asked what vision we have for the future, and whether we all share the same vision. What is our responsibility as a profession in catering to the needs of the country, and how do we ensure that we accept that responsibility? What is our value-system for the profession as regards both patient care and the education of future physiotherapists? What strategic plans should we be making for the future and how will these affect the special interest groups within the profession? She pointed out that we have to acknowledge that not all physiotherapists can work in all fields - we have to feel psychologically safe in our work - but that together we can support one another in proving the physiotherapy services which the country needs. She closed with a quote: “If you do not know where you are going, you may end up somewhere else and not even know it.”

S Irwin-Carruth