2. The proposed 7 million new members to enter the system largely already make use of our services! Some employers contribute towards these expenses. If these people are forced by legislation to contribute to a medical aid they will not be able to afford to see us out of pocket. Employers who will have been forced by legislation to make provision for employees' pre-funding of medical care will not have the resources to make any further contributions. Therefore we could in effect see fewer patients!

3. 'It will prove very difficult to contain costs in private healthcare without the use of staff private providers'! Patients will be forced to travel to a staff model clinic when the present infrastructure of accessible GPs is destroyed. House-calls for debilitated patients will be a thing of the past.

4. 'Primary care offered primarily in private sector capitated networks.' If these contracts are onerous in terms of the amount of risk the GP has to take, the quality of care will suffer and the GP's livelihood will be threatened further. I fear that the basis of allocating contracts will be price and not quality, with the patient suffering the consequences.

5. 'Selective contracting' implies that certain service providers will be left out in the cold. This also encroaches on the patient's right to freedom of choice.

6. 'Administration of funds will largely be kept in the hands of present institutions'. Private health care funders have done everything but prioritise primary care! This is where funding has gone wrong. Their history of corporate governance leaves a lot to be desired. In the past 10 years funding for GP services has declined substantially while non-health care expenditure (administration, etc.) has sky-rocketed by more than 25% per annum.

In conclusion, funds certainly need to be redistributed, but primary health care provision in the private sector, including care for previously disadvantaged groups, should receive priority as this is relatively underfunded (GP share less than 7% of total medical aid expenditure!). It seems perverse that a social health insurance system should perpetuate this unhealthy state of affairs.

The ultimate objectives should be equity and better health outcomes. Funding quality primary health care that is easily accessible has been proven to be the most cost-effective way of achieving both these objectives.

Equitable pre-funded universal coverage in South Africa should be based on freedom of choice to consult your family GP.

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Toy gun injuries

To the Editor: I refer to the article on toy gun injuries in a recent issue.[1]

We at the Tygerberg Hospital ENT Department have also noted the increase in referrals relating to toy gun pellets, with most of our patients requiring removal of these pellets from their ears under general anaesthetic. Eight patients required removal of foreign bodies from the ear under general anaesthetic in the first 6 months of this year. Six out of 8 (75%) of the foreign bodies were 'soft ball pellets', as described by Richards and Murray. This included one child who needed a post-auricular surgical approach, as even the professor of our department could not remove the pellet via the canal.

The typical situation involves a preschool child referred from a day or secondary hospital after an attempt to remove the offending item has proved unsuccessful. The child is usually unco-operative and understandably unhappy about strangers fiddling with its ears. By this time the pellet may have been pushed deeper into the canal by previous failed attempts at removal. These pellets seem to be of the perfect dimensions to wedge in the narrowest part of the ear canal, the junction between the cartilaginous and bony parts.

If the pellet is wedged in the ear canal, it is usually necessary to remove it under general anaesthetic, but if there is some space between the pellet and the ear canal, it may be possible to expel it by syringing. It is appropriate for a primary care physician to make one good attempt to remove the pellet, under the best possible conditions, with good lighting and the appropriate assistance and instruments. We recommend that no attempt be made to grab the object with a grasping instrument. It should preferably be syringed out of the ear. If a purpose-designed ear syringe is not available, we have found the use of a 20 ml syringe and a plastic drip cannula to be very effective. Careful explanation to both child and parent is required. The child may be swaddled in a sheet or towel to prevent excessive wriggling, and should be seated on the lap of the parent, who can steady the head and restrain the child if necessary. First the ear canal should be gently filled with lukewarm water, then a jet of water should be directed at the gap between the object and the canal wall, usually postero-superiorly. It will often pop out without much trouble. If this attempt fails, the patient should be referred to an ENT surgeon.

We would like to add our voice to that of our Ophthalmology colleagues (dare I say to provide more ammunition) to have these dangerous toys banned by appropriate legislation.

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1. Richards JC, Murray ADN. Toy gun injuries — more than meets the eye (Issues in Medicine). *S Afr Med J* 2003; **93:** 187-190.