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HASA NEWS

Exploring new healthcare frontiers

JULY/AUG 2008

NHI: all the talk

SWINE 'FLU reaching fever pitch

World population growing

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NHI Debate Requires Substance

Lucas Malambe, Editor Hasa News

No doubt the National Health Insurance (NHI) proposal is capturing the imagination of the nation and it is thus not surprising that the media has jumped on the bandwagon, if the amount of opinion pieces are anything to go by. In fact, the debate has been running on automatic since revelations about the African National Congress NHI Task Team Report were made at the Hasa Conference and Exhibition held in June in Durban.

The debates in the media are replete with more passion and rhetoric and belief than substance. Steven Koch lamented the dearth of economic research and evidence on such an important debate (Business Day, 14 August 2009). The professor in economics at the University of Pretoria is perhaps the right person to make such an observation.

None will disagree with the professor that the context of dealing with such an important proposal is to explicitly lay bare the linkages between the macro-economic environment and healthcare delivery in South Africa. Doing so will not only help the healthcare industry plug the delivery gaps, but will also help us identify the main issues that remain to be investigated and their relevance to future health policy.

As promised by the ANC manifesto on NHI, we must not be afraid of opening up space for actuaries, economists, healthcare specialists and other interested parties to explore the best universal healthcare coverage for SA. Since the turn of the century, the World Health Organisation has been calling for the use of health economics in healthcare policy-making.

To properly address the issues of future healthcare funding an understanding of how the health sector functions within the economy is important.

Firstly, proper research and debate helps policy-makers establish the right regimes for the healthcare system; it helps decision-makers to anticipate problems at the coalface of service delivery. Understanding the linkages between the economy and health services will help circumvent any jump-starts to any new model. Lastly, research and the engagement of stakeholders give a comprehensive view of the available resources for health.

It does not help anybody to discard, without investigating, the concerns raised about the links between payroll taxes and funding, for instance, if that is how the new regime is going to be funded. The thing is, health and the economy communicates through the money market. Financing of imported drugs, for example, is interconnected to the strength of the rand and the balance of payment. These links speak directly to the purchasing power of any budget.

As Koch observes, the NHI is not necessarily a bad thing, but the least we could do is acknowledge some of the gaping holes in the discussion, and work towards filling them. The sooner the Department of Health opens up the much-awaited debate on NHI, the better, as it will allow everybody, especially the private healthcare sector, to offer their contributions. In essence, such openness will encourage the department to take a fresh but realistic view of the issue in the context of both available and potential human and financial resources.

LETTERS
to the Editor

DO YOU HAVE A BONE TO PICK?
Email us your views with name, address and phone number to: contact@hasa.co.za

War talk ill considered

I am tempted to respond to comments made by Blade Nzimande, the South African Communist Party (SACP) secretary-general, about wars and capitalists. In fact, war is a misnomer in healthcare. We are all about healing.

The truth is the private sector has substantial intellectual capacity and resources, resources that the government will sorely need if it is to devise, plan and cost a system that has even the potential to work. The risk of a bad plan is too ghastly to contemplate. It may result in too many people succumbing to curable and manageable illnesses unnecessarily.

The devil will be in the design and so the costing. Do we really need something that will cost the taxpayer R100bn, or something efficient but cheaper? Sadly, the answers requires intensive research that is sorely missing in this debate.

James Donwald, email

Capitalist class

The country's public health system is in shambles and seriously needs a facelift. Newspapers point to poor service delivery, abandoned hospitals cost the system millions of rands and scores of patients are turned away because of lack of medicines. It is strange that nobody talks about these issues so that a solution can be found.

It is unfortunate that Higher Education Minister Blade Nzimande seeks to oversimplify a complex matter. He labels those who seek clarity on the implications of the national health insurance (NHI) to our health system as being zealously capitalist.

The country needs all its resources to deal with this colossal let-down to patients. I do not know what this "capitalist class" Mr Nzimande is referring to is supposed to mean, but I am certain if he looks around he would appreciate the great strides made by the private health system in this country, providing life-giving healthcare facilities that have saved millions of lives.

Dudu Mlaba, Durban

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SWINE 'FLU

Jacqui Pile,
The Financial Mail, 30 July 2009

Government has changed tack on dealing with the swine 'flu epidemic. When the H1N1 virus first hit SA, hospitals were asked to test all patients presenting with 'flu-like symptoms. If they tested positive, staff were required to trace everyone with whom the victim had been in contact.

"This model for containing the epidemic simply wasn't sustainable in terms of resources," says National Institute for Communicable Diseases deputy director, Lucille Blumberg. "We were overloading an already stretched diagnostic system."

The shift is in line with changes to the World Health Organisation's (WHO) reporting requirements on H1N1. In July, WHO said the rapid spread of the virus and rising number of cases in many countries made it difficult to confirm cases through laboratory testing. It said the outbreak was characterised by mild symptoms and most patients recovered, even without medical treatment, within a week of the onset of symptoms. The virus has spread internationally with unprecedented speed. Past 'flu pandemic viruses took six months to spread as widely as H1N1 has spread in six weeks. WHO added that all countries should monitor unusual events such as clusters of severe or fatal cases.

By end of July, 153 cases of swine 'flu had been confirmed in SA. Most patients were sent home to recuperate, says Blumberg. "This really is a moderate illness compared with other outbreaks, such as Avian 'flu."

Two drugs are used to treat swine 'flu: Tamiflu, produced by Roche, and Ralenza, made by GlaxoSmithKline (GSK). JP Morgan says new antiviral drugs could boost sales for GSK and Roche by US$1,8bn in rich countries and up to $1,2bn in poorer ones.

Blumberg says government has some stockpiles of Tamiflu, but chose not to stockpile Ralenza, which must be inhaled and is more difficult to administer.

SA generic producer Cipla Medpro stands to benefit. It produces Oseltamivir, a generic of Tamiflu. Private healthcare facilities have been stockpiling the drug. "We expect Oseltamivir to contribute significantly to our sales this year," says Cipla Medpro CEO Jerome Smith.

Tamiflu retails for R33 per capsule, Oseltamivir for about R25. A course of ten is usually sufficient to treat swine flu. Aspen Pharmacare doesn't have a generic antiviral on the market. It was awarded a voluntary licence to produce a Tamiflu generic in 2006, but only for public-sector stockpiling in Africa to treat Avian 'flu. "We never exercised the right, because it takes two years to complete the technology transfer required, and Avian 'flu was brought under control quite quickly," says Aspen senior executive Stavros Nicolaou.

Some states have asked the World Trade Organisation to be allowed to override patents on some drugs by issuing compulsory licences. Government could issue a compulsory licence for antivirals if swine 'flu were deemed a national emergency, says David Cochrane of intellectual property firm Spoor & Fisher. "There have been a number of applications for compulsory licences for other products, such as pesticides, in SA's high courts, but so far none has been successful," he adds.

India and Taiwan have issued compulsory licences on Tamiflu. Nicolaou says: "Though voluntary licences are a non-adversarial solution to a public-health crisis, compulsory licences can discourage foreign investment."

Transformation goes beyond black and white

Dr N S Matlala, Hasa Chairperson and Executive Director, Medi-Clinic SA

TRANSFORMATION IS ABOUT CREATING A HEALTH SYSTEM THAT IS TRULY EQUITABLE AND PROVIDES QUALITY SERVICES TO ALL SOUTH AFRICANS.

When we talk of transforming healthcare, we tend to think in terms of black and white. How many senior black managers are there in the bigger private hospital groups? How many small black businesses have been set up as suppliers? However, transformation goes much further – it's about creating a health system that is truly equitable and provides quality services to all South Africans.

The private hospital sector can play an important role in assisting the government to ensure transformation succeeds.

For more than a decade, we have been fiddling with a system that was designed for a different country. Apartheid set us back decades in terms of democratised healthcare. Other nations, such as the UK and Switzerland, began implementing national health systems that would deliver healthcare to all their citizens after the Second World War. Meanwhile, SA was preoccupied with creating different tiers of healthcare for different races. And when we stopped discriminating on the basis of race, we started discriminating on the basis of economics.

One of the biggest challenges for the new government under President Jacob Zuma will be to implement the national health insurance (NHI) system. This system will enable every South African to access fair medical treatment at a point of service. Although the details of this plan still need to be ironed out, NHI would see healthcare providers such as hospitals being paid by the state to provide a service to each person they treated. No one would be turned away at a hospital because they couldn't pay.

A more open, consultative and inclusive relationship between the public and private sector is critical if transformation is to succeed. The appointment of Pakishe Aaron Motsoaledi as the minister of health is appropriate and is welcome by those who know him. He, just like his deputy, Molefi Sefularo, has a full understanding of healthcare in the hinterlands of this country, having worked at the coal face for years under much more difficult conditions.

During the apartheid years, Motsoaledi worked in organisations intent on transforming healthcare in SA. Post-apartheid, he continued to be involved with the African National Congress (ANC) health and education committee. The private healthcare sector is encouraged by his reputation as a straight talker and a hard worker, with a passion for service delivery and a real understanding of the issues.

However, there are a number of challenges we face. Perhaps the most critical concern revolves around the chronic shortage of healthcare professionals. If NHI is to be successfully implemented, we need enough healthcare professionals to deliver the services. When the ANC came to power in 1994, there was a rationalisation in terms of human resources in the healthcare sector. Posts were frozen and a number of specialist skills were lost.

More than a decade down the line, the country faces a deficit of about 70 000 nurses, doctors, specialists, pharmacists and other healthcare workers. This shortage does not take into account the increased disease burden, such as more patients with HIV/Aids, nor does it factor population growth into the equation. Exacerbating the healthcare skills crisis is the fact that state nursing colleges have been mothballed.

In order to ensure its own survival and meet the skills shortfall, the private hospital sector began training nurses. In 2007, private hospitals trained 1 200 nurses. While

some of these nurses work in the public sector, the number graduating each year is still below the estimated additional 3 500 to 4 000 nurses required each year if the country is to deliver care to more people. We believe that the government should reopen all nursing colleges as a matter of urgency.

The private sector would also be willing to assist the state with training world-class doctors and specialists, but would require permission to do so. Trainee doctors and specialists could greatly benefit from exposure to the latest technologies housed in private hospitals as part of their training.

The state should engage more with the private sector in terms of public-private partnerships on a scale previously implemented at Hewu, Shiluvani and Matikwane hospitals, where comprehensive management, including clinical management, was in the hands of the private sector.

The recently opened Port Alfred Settlers public-private partnership gives much hope for the future, since it allows for clinical management of patients, unlike many other public-private partnerships we have seen.

While the private sector contributes 22% of SA's hospital bed capacity, one of the best ways to improve access to healthcare for the majority of South Africans would be to open some of the mothballed beds in the public sector and allow the private sector to help manage some of these hospitals.

It also seems unfathomable that South African private hospital groups are being contracted by some European governments to help address their backlogs of patients waiting for surgical procedures, yet in SA this model has not been utilised. Our companies meet the strictest quality control standards and outperformed bidders from across the world to win these contracts.

Although the same hospital groups undertake surgical procedures as part of their corporate social responsibility programmes locally — for example, thousands of cataract operations are performed each year for free at various private hospitals — this is not a sustainable economic model. If the state were to buy these services from the private sector, the huge backlogs of surgical patients in public hospitals could be eliminated. This would be at little additional cost to the state because of the efficiencies extracted.

Two of the most important aspects of the healthcare system the incoming minister will need to consider are the poor leadership and structural weaknesses that currently characterise the system.

Priorities should include changing regulations to empower hospital administrators so that they are not handicapped in responding to local needs. Under the existing system, they are hamstrung while waiting for decisions from provincial heads. The end result of this arrangement is that patients suffer.

The fact that SA has failed to make much progress in meeting the Millennium Development Goals of reducing HIV/Aids, communicable diseases and maternal deaths is an indication that the health system is performing poorly.

It is evident that the government will have to move quickly if it is to address the healthcare catastrophe. The private hospital sector has historically contributed to programmes aimed at improving access to healthcare, both on a collective and individual level, for patients beyond those who can afford private hospitals.

We urge the government to engage the private sector to truly transform healthcare for all.

The NHI's building blocks are in place, but we have to be certain it will work

Neil Kirby,
The Cape Argus, 5 August 2009

Recent government documents have detailed the plans for a National Health Insurance (NHI) scheme for South Africa.

Membership will be compulsory and funded from a levy or tax deducted from the salaries of those in the formal sector and by the state for the unemployed.

The NHI will, as it is proposed, be implemented over five years, meaning by 2014.

NHI is nothing new in larger, wealthier democracies. The question is whether such a system is a good fit for South Africa.

Surprisingly, this question has already been answered in part. On reading the NHI document, one realises that much of the proposed scheme is already in place - it's just a matter of connecting the dots.

The advent of NHI was set out in the national drug policy published in 1996, so proposals on NHI are really not novel.

In that policy, NHI is premised on the ideology that all South Africans are entitled to access healthcare services. This ideology became entrenched in the Bill of Rights and is a constitutional prerogative for the government.

Construction of NHI infrastructure began at the turn of the century with a succession of significant amendments to healthcare legislation, affecting all aspects of access to healthcare:

- The Medical Schemes Act was amended to remove risk-rating and allow more equitable entry criteria.
- Community service was introduced for healthcare professionals and pharmacists.
- Larger corporations were allowed to enter the pharmacy industry and, in theory, use their economic muscle to provide cheaper pharmacy services.
- The base of primary healthcare providers was broadened to include allied professions and traditional healers.
- Regulated medicine pricing was ushered in and the medicines base was widened to include traditional Western, herbal, Chinese and Indian medicines.
- Certain managed-care solutions were introduced for medical schemes, enabling them to negotiate cheaper membership rates.

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R3,2bn injection for hospital revamp

Slindile Khanyile,
Business Report, 6 August 2009

The Department of Health will spend R3,2 billion this year on refurbishing 54 government hospitals, according to the department's spokesman, Fidel Hadebe. He said the department and provinces were working on determining the overall cost of refurbishing all the facilities. Last week, Zweli Mkhize, the chairman of the ANC sub-committee on health and education, said the government could not afford to fix the dilapidated state-owned hospital buildings on its own and it would need billions in funding help from the privately owned health groups.

An audit completed in 1998 showed that it would cost R28 billion to upgrade all the government hospitals in the country. Hadebe said that provinces were asked to review the capital needs for all health facilities that needed upgrades, renovation, rebuilding and new installations. The hospital revitalisation programme started in 2002/03 and 13 hospitals have been refurbished thus far. Hadebe said the discussion on public-private partnerships (PPPs) was continuing. Life Healthcare has confirmed that it was talking about PPPs with the government, but said these talks had been on an informal basis.

Adam Pyle, the marketing manager at Life Healthcare, said if the government wanted value out of PPPs it should allow the private hospital groups to provide clinical services. In its PPP model for a bigger refurbishment programme, the government is at present only offering private healthcare groups the option to fund the projects and to provide services such as cleaning and catering. Life Healthcare has a PPP at Humansdorp. It also owns Life Esidimeni, which is the oldest PPP in the country, where it operates 14 facilities under contract for the provincial government.

Nkaki Matlala, the chairman of the Hospital Association of SA (Hasa) and a clinical officer at Medi-Clinic Southern Africa, said the private companies were willing to help the government with the management of hospitals, training of nurses and reducing the long queues in hospitals. He said that the private sector had been saying for a few years that it wanted to join hands in improving all healthcare in the country because it was not sustainable as a corporate social investment project.

The ANC's Mkhize said the refurbishment had to happen concurrently with the phasing in of the government's national health insurance scheme.

NHI FOR SOUTH AFRICA

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- The concept of accrediting healthcare providers was introduced.
- The national health reference price list was published. In the light of proposed amendments to the National Health Act, it becomes a maximum price for healthcare services.
- The Medical Schemes Act already makes provision for prescribed minimum benefits and other guaranteed services, which shadow the NHI.

The NHI is basically a large medical scheme – to be governed by a board or trustee-like body and providing a prescribed set of benefits from a prescribed set of healthcare providers for a certain cost.

This formula is already used in the Government Employees Medical Scheme, which uses legislative structures to give government employees access to healthcare at the best available price - in much the same way as NHI will provide benefits to the public.

Certainly, I risk the criticism of espousing conspiracy theory.

However, armed with the ideology in the national drug policy and viewing the nature, type and effects of new and amended healthcare legislation, one is left with the indelible impression that the fundamentals of NHI are in place, silently awaiting their final deployment.

However, if we are dissatisfied with the current state of healthcare or access to healthcare services, should we not be supporting NHI?

The point is that if one is to implement a NHI-type solution, then its efficacy, quality and cost must be examined. But such a system excludes a consideration of healthcare outcomes and quality – all it promises is access, but access to what?

The state of South African healthcare is far from simple and providing universal access is laudable, as well as a constitutional directive. However, one must be certain that NHI will achieve efficacious and quality healthcare and not just promise it.

I'm not sure I want cheap cardiothoracic surgery without the feeling that I know it will work or fearing that I'll contract some other fatal condition due to badly equipped or under-maintained facilities.

Based on our experience to date, and thinking really hard about what healthcare is, does NHI promise anything different from that with which we are already saddled? Is it a gift horse?

It's a case of exercising care over what it is exactly that you wish for… as you may just get it.

Neil Kirby is director: health, pharmaceutical and life sciences at Werksmans, Incorporating Jan S de Villiers, a leading corporate and commercial law firm.

Smoother systems could ensure more have better access to healthcare

By Judy Gilmour, *Financial Mail, 29 July 2009*

Along with all South Africans, the private healthcare sector is awaiting government's National Health Insurance (NHI) proposals that aim to improve access to and quality of health care in the country.

The ANC Policy Conference in December 2007 made it clear that the ruling party was committed to the "implementation of the National Health Insurance System by further strengthening the public healthcare system and ensuring adequate provision of funding".

For the private hospital groups in SA, the role of the sector in a new NHI system still needs to be clarified. And though the private hospital sector most certainly supports improved access to and quality of healthcare, there are concerns that there has been no public discussion and debate to date.

Nkaki Matlala, Hasa chairman (Hasa) and Medi-Clinic executive director, says many progressive countries all over the world apply the concept of NHI and universal access, the overriding intent of which is to bring about a fair and equitable system. "But how each country then implements universal access can vary significantly. It would depend on that country's unique demographics, geography and economic strength."

Matlala says that as far back as 1944, a national health service for SA was mooted, in line with many other countries that were reviewing the option at that time. "But our apartheid policies clashed with the underlying thrust of a public health system – universal access to healthcare. And now, more than half a century later, in a democracy, we are seriously re-examining the concept."

Supportive of the principle behind NHI, Matlala says that SA should eventually have a well thought-through system, which should be adapted to the uniqueness of the country. In addition, all stakeholders should contribute towards its shaping and final form.

He says any planning for NHI should not only focus on inputs such as health professionals, financial aspects, technology and infrastructural improvements, but also on the quality of care.

"If quality does not improve, it is not much use for the nation. NHI must bring about quality changes and South Africans must be able to clearly notice these changes at the point of service."

Hasa CEO, Kurt Worrall-Clare, says that private hospitals endorse the principle of NHI, which is essentially about improving access to healthcare by ensuring an appropriate financial and healthcare delivery model and universal health coverage for all. In the absence of any detail pertaining to the applicable model within SA, it is highly likely that industry, consumers and other affected parties will take a cautious approach to any NHI proposal.

The process of implementing an NHI scheme must be engaging, with all stakeholders participating in both the debate and the formulation of appropriate policy to ensure improved access.

"We also acknowledge the role of the private sector in improving the quality of healthcare. The private healthcare sector has valuable intellectual capital that could be leveraged to provide a solution to SA's healthcare problems," he says.

Worrall-Clare cautions against placing too much emphasis on the NHI model adopted by more developed countries, which have far broader and more sustainable tax bases.

"In SA, a relatively small portion of the population would be required to assist with funding NHI and significantly more resources would be required if public health establishments are to be upgraded, equipped and resourced with additional human capital. The funding mechanism needs to be carefully determined and should ensure the sustainability of both the private and public healthcare sectors," he says.

It should also be noted that though NHI is an important feature of the current SA healthcare debate, there are numerous ways in which the goal of improved access to healthcare could be achieved.

Ultimately, the country must develop a model of healthcare delivery that is both appropriate and designed around patient needs, and which is founded on empirically supported research, he says.

HEALTH AWARENESS

SEPTEMBER

National Heart Awareness Month

National Oral Health Month

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Nursing crisis
calls for unified response

At a time when the annual output of professional nurses has fallen dramatically, the private hospital sector continues to play an important role in addressing the shortage of nurses in South Africa.

There are nearly 42 000 vacancies for nurses in the public sector, while the private sector anticipates it will face a shortage of 18 000 nurses by 2014. The nursing shortage is expected to worsen as an estimated 22% of all nurses will be retiring in the next ten years.

While government has mothballed nursing colleges, hospital-based private nursing colleges have stepped into the breach, training about 6 000 nurses each year.

A new paper by the Human Sciences Research Council (HSRC) asserts that private hospital academies offer courses that are specific to their needs and that no private training school has been able to meet the requirements to offer a four-year degree or diploma, which must include midwifery, community and psychiatric nursing and general nursing.

This is inaccurate and misleading. The New Nursing Act of 2005, which defines new categories of nurses, has meant the SA Nursing Council (SANC) has been in a state of flux for the past few years, impacting on the country's ability to train quality nurses. Despite the shortage of nurses, for the past five years there has been a moratorium on the registration of new nursing training courses as well as the accreditation of new private hospital nursing schools and the number of students who can be trained. Although there has been ongoing dialogue with the SANC, pointing out the dire consequences of the extended moratorium, repeated requests for the lifting thereof have been denied. This extended moratorium is the result of a delay in the publication of the regulations governing nursing training standards and curricula.

Although the private sector has wanted to offer four-year nursing courses, it has been unable to do so because of SANC restrictions – and not because its training colleges failed to meet the requirements.

In 2004, for example, Life Healthcare applied to the SANC for approval to implement the four-year training programme, having identified adequate clinical facilities to meet the training requirements for midwifery, community health and psychiatry. The programme and clinical facilities were approved subject to registration with the Department of Education and accreditation by the Higher Education Quality Council. This has still not happened. The bureaucracy around the approval of new nursing courses is inhibiting the ability of private training institutions to train more nurses.

In the absence of adequate numbers of registered nurses, the bridging programme has enabled the private sector to train registered nurses. Despite not being allowed to train nurses over four years, the major private hospital groups have continued to fund nurses at degree and diploma level at universities and provincial colleges, thus enabling them to complete the four-year diploma and degree programmes.

It should also be pointed out that private hospital academies do not only offer specialised courses that are geared to their specific needs. The private sector has been involved in a number of public-private partnerships to support the training of specialist nurses. Between 2004 and 2008, for example, Life Healthcare supported the Limpopo Department of Health with training specialised nurses and supported the Limpopo Nursing College to develop and obtain approval for its own post-basic training programmes.

Over 100 specialist nurses were trained during this time. As part of the same project, capacity building of provincial nurse educators was also achieved. Other public private initiatives include the Certificate in Neonatal Intensive Care with the Charlotte Maxeke Hospital and Wits University (also supported by Life Healthcare) and training provincial nurses in infection control.

An average of 2 500 students a year are registered and enrolled at Netcare's five accredited training campuses throughout the country. These students include Netcare and non-Netcare employees. Among others, Netcare has a strong working relationship

with state hospitals in both the Eastern and Western Cape from a training perspective.

Medi-Clinic's nursing training commenced in 1997. The hospital group currently has six SANC accredited learning centres and over fifty skilled nurse educators. The Higher Education Act of 1997 (Act No 101 of 1997) necessitated that all private providers of formal higher education qualifications register with the Department of Education. The higher education band provides the highest level of education and entry into higher education is via a Grade 12 pass or Grade 12 pass with exemption. Medi-Clinic has been granted provisional registration status as a provider of higher education. At the end of 2009, the organisation will be eligible to apply for conversion to full registration status.

It is important to separate the private, non-hospital training institutions from the hospital-based nursing education institutions.

It is important to separate the private non-hospital training institutions from the hospital-based nursing education institutions. The rapid growth of the former has been based on accreditation and approval by the SANC. Nursing requires adequate clinical facilities for quality training and to allow these private nursing colleges to continue training nurses in sub-standard clinical facilities is a flaw in the SANC's accreditation system.

Private hospitals also provide excellent training facilities for nurses from universities, with access to modern technology. Many of the universities involved in clinical post-graduate training use private hospitals for clinical placement of their students. While training in private hospitals is largely hospital-based, these courses prepare nurses to participate in the delivery of healthcare in a variety of settings.

Other contributing factors to the nursing shortage outlined in the HSRC report are falling nursing standards, risk of HIV and TB infection and lower salaries when compared with other professions that have required four years of training. The HSRC report also states that nursing was at best a second career choice for many women. These factors need to be addressed holistically by both government and the private sector.

The South African Qualifications Authority (SAQA) has announced that current nursing qualifications will cease on 30 June 2010 and thereafter no new students for current courses will be accepted. Unfortunately, no date is available for the commencement of new courses.

It is time to acknowledge the efforts of all stakeholders in the delivery of quality nurse training. The nursing shortage – which is crippling the delivery of quality healthcare in both the public and private sectors – does not provide us with the luxury of drawn out debate over whether the public or private sector should train nurses. Both the public and private sectors have a valuable role to play in addressing the problem. The crisis in nursing numbers calls for all hands on deck to train more nurses in order to meet the demands of the country's healthcare system.

Critical shortage of nurses

Prakash Naidoo, *The Financial Mail, 7 August 2009*

Deep cuts in provincial budgets and the restructuring of the higher education system have resulted in a critical shortage of nurses. Public training in the profession has declined substantially in recent years.

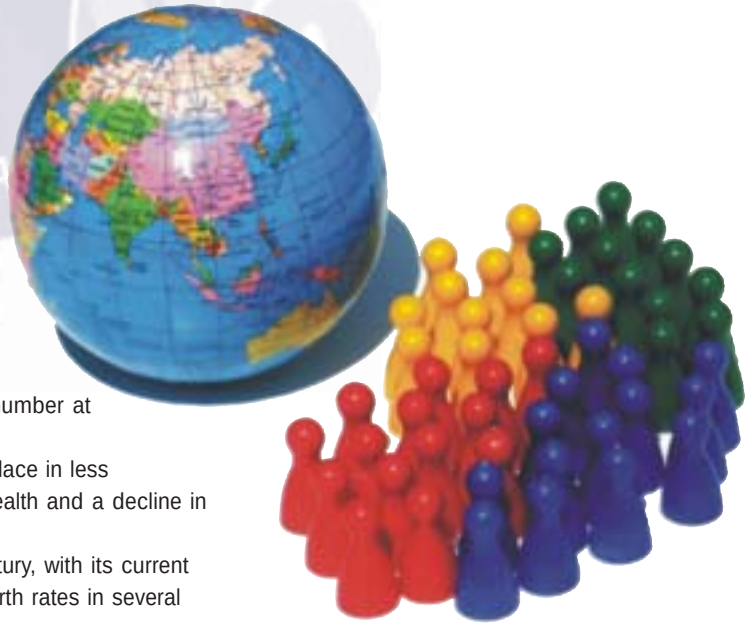
A major new study by the Human Sciences Research Council has found that budget cuts have halted many public hospital training programmes, while restructuring led to the closing or merger of public nursing colleges. With an increasing emphasis on the university nursing degree rather than the four-year college diploma, college output has dropped while university output has increased slowly, but from a low base.

Between 1997 and 2007, the annual production of professional nurses overall increased by 19% as a result of the doubling of the output from bridging programmes (from 1 033 to 2 093 over the period). At the same time, the output of professional nurses through four-year college and university courses fell by 13% – from 2 682 in 1997 to 2 342 in 2007. Apparently, most of the bridging training has occurred in the public sector, but the numbers declined from 1 381 in 1998 to 1 261 in 2007, while private-sector output increased more than five-fold, from 158 to 832. The contribution of public colleges to the production of professional nurses declined from 62% to 37% of the total output, while university output rose from 10% to 16%, and output from the bridging programme increased from 28% to 47%.

The study suggests the private sector is now playing a much larger – and often lucrative – role in the production of nurses. The major hospital groups, in response to their own severe shortage of nurses and to accusations that they poach from the public sector, expanded their own training programmes, producing increasing numbers of nurses to meet their own specific needs. At the same time, small private colleges have mushroomed.

The study urges government to play a greater role in the training of nurses, and suggests that the "new emphasis on a professional nursing degree as the qualification of choice should not be at the cost of deterring young people who would make excellent professional nurses but do not meet the academic criteria for university study, or who see the university degree as too theoretical".

World population 9,4 billion by 2050



Global population numbers are on track to reach 7 billion in 2011, just 12 years after reaching 6 billion in 1999. Virtually all of the growth is in developing countries. And the growth of the world's youth population (ages 15 to 24) is shifting into the poorest of those countries. This is according to The Population Reference Bureau's *2009 World Population Data Sheet*.

That number could reach as much as 9,4 billion by 2050. The estimate compares with a recent UN figure, which projected the number at about 9,1 billion.

Between 2009 and 2050, nearly all population growth will take place in less developed countries, where there have been increases in public health and a decline in death rates, the report said.

The Asian population is expected to grow the most by mid-century, with its current population of 4 billion increasing by 1,3 billion, despite declining birth rates in several countries like Japan.

African population to double

Africa, the region with the highest birth rates and largest percentage of population growth, is projected to see its current population of nearly 1 billion double by 2050. The table right shows the growth of Uganda despite a low life expectancy rate due to HIV/Aids. The median age for Uganda is just 15.

The population of Latin America and the Caribbean is expected to see a modest increase of 25% to 724 million by 2050.

The US population is expected to grow from 307 million to 439 by 2050, largely due to immigration.

Low birth rates are expected to shrink Europe's population from 738 million to 702 million, despite continuing immigration, the report said.

Greying of the population

The world's 65-and-older population will triple by mid-century to one to six people, leaving nations struggling to support the elderly. The number of senior citizens has already jumped 23% since 2000 to 516 million, according to census estimates released in August. That is more than double the growth rate for the general population.

This greying of the population will put pressure on healthcare utilisation, which may drive the world's medication inflation sky high. More and more people will seek healthcare because of the ailments that comes with age. In South Africa medical schemes report a slight increase of people in the 40-to-44 and 60+ groups. Older age groups are high claimers of healthcare services, and the need for higher level of care will drive up medical inflation and hospital cost.

KEY DEMOGRAPHIC INDICATORS IN THREE COUNTRIES - 2009

	United States	Canada	Uganda
Population mid-2009	307 million	34 million	31 million
Population 2050 (projected)	439 million	42 million	96 million
Percent of population below age 15	20%	17%	49%
Percent of population ages 65+	13%	14%	3%
Percent of population ages 15-24	14%	13%	20%
Lifetime births per woman	2.1	1.6	6.7
Annual births	4.3 million	371,000	1.4 million
Annual deaths	2.5 million	244,000	384,000
Life expectancy at birth	78 years	78 years	50 years

"If anything, there's agreement on the need to collaborate on NHI, and so we're talking to them quite actively with a view to trying to resolve the issues." Discovery boss, Adrian Gore, on talks with the Board of Healthcare Funders.

"War"against capitalists", is how Higher Education Minister Blade Nzimande sees the imminent debate about the implementation of the suggested National Health Insurance (NHI) system.

"After years of pointing fingers at each other, we realise that co-operation and mutual assistance are key to finding a solution to healthcare problems in SA." Nkaki Matlala, Hasa chairman and Medi-Clinic executive director, says the healthcare sectors in SA are now in a different era.

"When you go to see them, you become an irritation," says Health Economist, Alex van den Heever, about what he sees as negative incentives about the GP model being proposed in the NHI initiative, as NHI-accredited GPs will have a guaranteed income, there being incentives for doctors to refer patients to specialists instead of taking the time to treat them themselves.

Real Medical Aid
FEDHEALTH

"You get what you pay for," said Fedhealth principal officer Peter Jordaan when explaining the medical aid scheme's refusal to provide figures of members running out of funds.

"Universal NHI is not necessarily a bad thing, but the least we could do is acknowledge some of the gaping holes in the discussion, and work toward filling them," said Prof. Steven Koch exhorting the country to use economic research and evidence as a starting point in debating NHI.

PRESIDENT JACOB ZUMA SAID THE proposed National Health Insurance (NHI) scheme would help reduce the number of women who have no access to quality healthcare. Speaking at a Women's Day ceremony, Zuma said SA could only measure the progress it had made since democracy by increasing the number of women who had access to quality healthcare. He said that improving the health of South Africans, especially women and children, was a key priority for the government, suggesting the NHI was key to achieving this objective. He said some hospitals needed refurbishment while others were in good shape, but were run by incompetent managers who were not committed to the health of the people. Zuma said that people were saying that at some clinics they were given painkillers only for every ailment, as there was nothing else available. A key solution would be the introduction of NHI for the country, he said, adding that the scheme's broad objectives were the funding and health delivery mechanisms. His comments come in the wake of warnings by Higher Education Minister Blade Nzimande that there would be "war" against capitalists if they tried to block implementation of the system.

Sipho Khumalo: The Mercury, 10 August 2009

MAJOR AMERICAN HEALTHCARE groups are promising that the August legislative recess will be filled with advertising wars trying to manage the message of the healthcare reform debate. America's Health Insurance Plans is sinking millions of dollars into an advertising blitz defending itself, as Democrats and the White House turn the industry's practices into a rallying call for reform. In the last health overhaul battle, industry stakeholders came out squarely against reform and invested heavily in ads to kill it. This year, many big players are trying to avoid getting tagged as the group that killed reform. So their ads, at least for now, are generally supportive of the reform effort, but hazy on their positions on the exact language of the House and Senate proposals. Of the ads that have aired, $17,3 million have been in favour of Obama's reform plans. About $8 million has been spent on commercials opposing it. In total, $51 million has been spent on ads since Obama took office. About $22,5 million has been pro-reform, but neutral on the details.

News-Medical.Net, 5 August 2009

THE BOARD OF HEALTHCARE Funders (BHF) has released a proposal for a National Health Insurance (NHI) system that would make use of existing medical schemes, as opposed to a leaked government proposal for an NHI that would replace medical schemes. Although details of the proposed NHI system have not yet been released, the government says it will offer a comprehensive package of healthcare services in line with those available in the public sector. The leaked document, drawn up by an ANC-appointed task team, proposed that an NHI authority be established to take over the role of funding and purchasing these healthcare services in both the public and private sectors, negotiating prices for services and paying accredited doctors, hospitals, pharmacies and other healthcare providers, both public and private, on the patient's behalf. In essence the proposal is that this authority takes over the role of medical schemes. However, the BHF suggests that existing schemes can play a role by offering NHI benefit packages that are paid for with the money allocated to the NHI agency.

Laura du Preez: Personal Finance, 1 August 2009

PRIVATE HEALTHCARE REMAINS expensive and requires a funding structure like the National Health Insurance (NHI) to increase access to quality healthcare, according to Anil Bramdev, the secretary of the KZN Specialist Network. Bramdev said the network was committed to making the NHI work. He said one reason for the escalation of costs was the administration fees charged by the medical aid funders. He said it was not just about the doctor and the patient only – the private sector was doing good quality work, but it was very expensive. KZN Specialist Network represents 300 specialist doctors in KwaZulu-Natal and invited Zweli Mkhize, as the chairman of the ANC sub-committee on health and education, to talk to the network about the NHI. Mkhize said the ANC was not trying to eliminate the private healthcare sector and urged doctors and other stakeholders to engage constructively with the government on the issue. He said the inequality gap had widened between high- and low-income earners, which had seen the membership bases of medical schemes shrinking. He said the challenge was to find a formula that would create a system that would not perpetuate these disparities, adding that a confrontational process would not do anyone any good.

Slindile Khanyile: Business Report, 31 July 2009

HEALTH UNIONS REPRESENTING doctors in the public sector have signed the Occupational Specific Dispensation (OSD) agreement with the government. This has brought to an end the drawn-out talks with the sector that led to doctors going on strike. However, the Democratic Nurses' Association (Denosa) said a reviewed offer of certain salary scales was in the pipeline. The union said without this undertaking it would not have signed the agreement. Last month, the South African Medical Association (Sama) doctors rejected the government's R1 billion OSD salary increase offer at the time.

SAPA, 12 August 2009

SOUTH AFRICA'S FIRST RECESSION in 17 years might be to blame for the increase in stress-related illnesses. Pro Sano Medical Scheme's operations executive, Dr James Arens, said that stress-related conditions might well be linked to the recession and affect people of all ages and incomes. Quite simply, he said, it seemed as though money worries and job insecurity were making people sicker and were leading to increased hospitalisation and medical treatment. Arens said a number of medical schemes had reported a big change in claims patterns, adding that claims expenditure in

the first half of the year was usually much less than had been seen this year. Normally there were peaks around May, June and July linked to winter ailments, but claims received in the first part of 2009 were almost as high as mid-year claims, which was "worrying", Arens said. He said his medical scheme had noticed a significant increase in serious ailments, such as cardiovascular illness – hypertension, strokes and heart attacks – as well as in psychiatric conditions such as depression. These conditions might well be linked to the recession, he said.

The Times, 12 August 2009

GOVERNMENT IS LAUNCHING AN intensive information campaign to help people cope with the swine 'flu pandemic as the number of infections in South Africa rises, said Health Minister Aaron Motsoaledi. Motsoaledi said he would record advertorials to be aired on national television and radio and community radio stations, explaining the symptoms of the virus and advising on the best response to it. He was also planning to send letters to schools, religious leaders and trade unions, as well as MPs and traditional leaders, while the ministry would distribute leaflets at malls and taxi ranks. Motsoaledi said South Africa so far had 1 910 confirmed cases of swine 'flu and three deaths. South Africa has to position itself as a destination of choice for medical healthcare ahead the 2010 Fifa World Cup, Deputy Health Minister Dr Molefi Sefularo said. "It is a wave that you will all have to catch," he said at the South African health tourism conference at the Sandton Convention Centre. "The management and co-ordination of infectious disease importation, including emerging and re-emerging infections, needs centralised leadership." He said diseases, such as swine 'flu, bird 'flu, Congo fever, polio and extremely drug resistant tuberculosis needed central control and management. "The health tourism industry should work with the national department of health in managing these areas." Sefularo said in a statement that this approach was important for communication, security, integrated disease response and intervention.

Sapa, July 2009

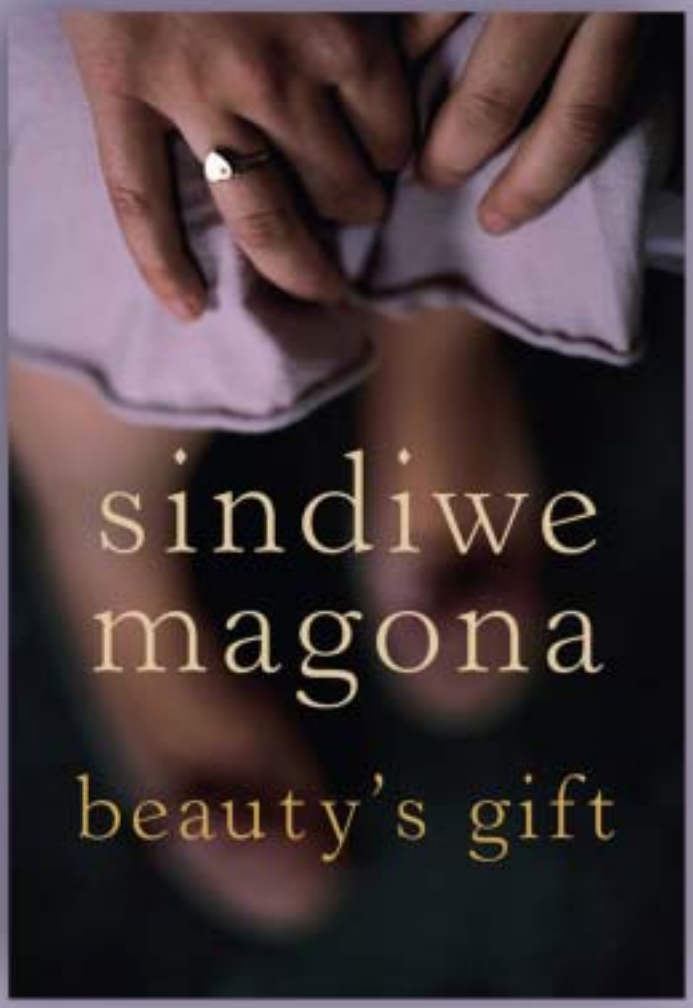
NURSE YOUR HEART

The Book: Beauty's Gift
Author: Sindiwe Magona
Reviewer: Lucas Malambe
Verdict: Beautiful story by a master teller of tales

Sindiwe Magona is a veteran of many celebrated books, including *To My Children's Children, Push Push, Forced to Grow* and *Mother to Mother*. Magona may have lived overseas for many years, but she speaks with authority on the hard knocks of township life. In *Beauty's Gift*, Magona tackles the sensitive issue of HIV/Aids, taboos and the effects of patriarchy on women. The tale begins with five childhood friends who discover that one of them, Beauty, is dying of the disease they so dread. However, Beauty leaves them with a gift – to live longer.

Magona's power with the words is felt throughout the novel as she masterly takes us on a psychological and emotional journey of the remaining four grieving and angry friends. Is it too late, though, for some of them to live to old age? They take an oath to avoid unprotected sex, but the devil is that they are either married or engaged.

Magona's tale delves into the intricacies of the cost of SA Aids denialism. She uses influential people in community to give *Beauty's Gift* life. There is a strong story, beautifully4 interwoven in just the right words to keep the reader itching for more. It may be Magona's way of exhorting women to stand up to unscrupulous men and fight for the right to negotiate condom use in their complex relationships, but the mother's pain of HIV/Aids is laid bare in a riveting novel.



The eighteenth annual publication of the Hospital Association of South Africa

HEALTH *Annals* 2010

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