HASA NEWS

Exploring new healthcare frontiers

JUNE/JULY 2010

OVERVIEW OF Hasa activities

Local & International LEGAL DEVELOPMENTS

HEALTH ACTS

THE ROLE OF HASA

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

The Association represents 212 group and independent hospitals, with a total of 26 868 beds, about 90% of the beds and hospitals in the private sector. Hasa is seen by government to be the official representative body for the industry and is recognised by other stakeholders as the mouthpiece of the industry.

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

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

THE OBJECTIVES OF THE ASSOCIATION INCLUDE:

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

CONTENTS

JUNE/JULY 2010

IN MY VIEW 2
Vigilant as always...

Medical task team will not deal with PMB 'hot potato' 4
Uncertainty about controversial regulation

Medi-Clinic celebrates International Nurses Day 5
Medi-Clinic recognises their nurse practitioners contributions

Best Care Always and Gauteng collaborate on quality improvement 6
First workshop a success

Health Awareness Calendar 7

LEGAL WATCH 8
The National Health Act, 2003

Legal developments 9
Local and international legal developments

HUGGING THE FIGURES 11
Is there a doctor in the house?

NEWS IN BRIEF 12
Healthcare news snippets

NURSE YOUR HEART 13
Review of the novel, *Men of the South*

For further information on Hasa, access our website www.hasa.co.za or tel 011 478 0156.

HASA NEWS

House VII, Visiomed Office Park,
269 Beyers Naudé Drive, 2195 Northcliff
PO Box 4038, 2118 Cresta
website www.hasa.co.za

EDITOR AND PRODUCTION MANAGER

Lucas Malambe,
Executive Officer:
Corporate Communications

ADVERTISING SALES AND SUBSCRIPTIONS

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

LETTERS TO THE EDITOR/ ARTICLE SUBMISSIONS

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

BOARD OF DIRECTORS

Mr R Allie, *Melomed Holdings*

Ms M Da Costa, *Netcare Limited*

Mr J du Plessis, *Netcare Limited*

Dr V L Litlhakanyane, *Netcare Limited*

Dr N S Matlala, Chairperson, *Medi-Clinic SA*

Mr A Meiring, *Psychiatric Focus Forum*

Dr Diliza Mji, *eThekwini Hospital & Heart Centre*

Mr A A Nana, *Lenmed Clinic*

Mr A M Pyle, *Life Healthcare*

Mr P J Scott, *Life Healthcare*

Mr B Valodia, *Medi-Clinic SA*

Mr M C van den Berg, *Zuid-Afrikaans Hospitaal*

Dr K I M Shongwe, Deputy Chairperson, *Life Healthcare*

Adv K Worrall-Clare, *HASA CEO & Legal EO*

Mr O F A K Wypkema, *Arwyp Medical Centre*

***Dr S Vasuthevan,** *Life Healthcare*

*Ex officio

EDITORIAL POLICY

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

SKILLS CONTINUE TO POSE CHALLLENGES

Lucas Malambe, Editor Hasa News

High-level skill shortages are neither a new phenomenon nor unique in South Africa. The focus of this issue of *Hasa News* is human resources in health. The current shortages experienced in Sub-Saharan Africa differ markedly from those experienced in the past and in the rest of the world, as the local pressures go beyond the economic principles of supply and demand. The truth is that we are not training enough doctors and nurses to compensate for those we lose to other countries (see page 11).

As a result of the emigration of skills and inadequate training, the South African healthcare sector is facing a dearth of high-level healthcare skills. Rural areas and state hospitals are the hardest hit. There are more than 4 000 doctor vacancies in the public sector and medical schools continue to train the same number they did in the 1970s. Even more baffling is that policy makers are still insisting on capping the number of doctors (from other African countries) interested in working in SA.

We live in an increasingly globalising economy, where competition for scarce skills is at a premium. We have a competitive advantage in terms of lifestyle and humanitarian appeal and we need to rethink the policy of not recruiting professionals from other African states. The 2010 Soccer World Cup we are hosting proves the attractiveness of our country to the world.

Working near a rural area of the 'Friendly City' certainly sounds more appealing than in an underground dungeon, as many African doctors end up doing abroad. Certainly, the work experience that can be gained in the picturesque Mpumalanga cannot be compared to treating wet coughs in the cold climates of the northern hemisphere.

Vigilant as always...

Adv Kurt Worrall-Clare, Hasa CEO

'IT IS NOT A CASE WE ARE TREATING, IT IS LIVING AND, ALL TOO OFTEN, SUFFERING FELLOW HUMAN BEINGS.'

For almost 18 years, the Hospital Association of South Africa has diligently represented the interests of the private sector, and it will do so, for many years to come. With each passing year, its members are faced with new challenges, each of which seems more pronounced and pressing than ever before. Yet Hasa preserves, knowing that its sector has placed a significant investment in its patients, its community and country. Perhaps Benjamin Disrael said it best when he remarked on the 23 June 1877, "The death of a person is really the foundation upon which all their happiness and all their power as a State depend."

Indeed, healthcare is a significant basis upon which our democracy is founded, and it is often said that Hasa makes light of its importance in the lives of its people. Indeed, any nation which enjoys health is a nation which has found its power. It is for this reason that both the public and private sector are called to exercise due diligence, honour and respect, in the delivery of healthcare to those in need. Hasa is, after all, focused on people, who depend on those in charge, particularly when sick.

In the coming year, a great deal will be said of National Health Insurance (NHI) as a means of delivering an improved healthcare service to all, and the private hospital sector will not be exempt for that debate. It has already been argued by some, that both transformation and the progressive realisation of the right to access healthcare, as stated within our Constitution and the National Health Act, demand such. Others argue that improved utilisation of our current resources, under a responsible managerial system designed to deliver healthcare pragmatically and speedily, is the answer. Still others argue a combination of these positions.

Improved financing may indeed be part of the answer, as will additional resources. The two are equal parts, and one cannot exist without the other. In all Hasa deliberations, they are open to challenge, resolute in their commitment to well found and empirically supported evidence, free of any vested interests, be they political or economical.

HASA Matters

At the start of this year, the newly formed Remuneration Committee (established under an amendment of the Articles of Association in 2009), started a process of re-evaluating the Hasa employee "Conditions of Employment" and "Salary Structures". This process was initiated to ensure that the current positions within Hasa were independently and objectively reviewed, so as to ensure skill retention and the correct reimbursement of valued members of staff (particularly those that have had their responsibilities and positions changed over the years). In order to ensure independence, Hasa commissioned the services of 21st Century (Business and Pay Solutions) to conduct the investigation.

Some of the concerns and recommendations made by 21st Century, were already mooted by the Remuneration Committee; as such, the process was indeed complimentary. Without going into too much detail, Hasa has recognised that there is a risk from a talent management and retention point of view, and as such, it is necessary to enunciate programs for the retention of critical staff. For this reason, Hasa has established a subsidised study scheme, which will assist staff members to further their studies (provided they meet the internal and external needs of the Association).

An additional recommendation made to Hasa was to review its organisational

structure, with specific reference to its mandate and strategy.

The National Health Price Reference List

The NHRPL promulgated in terms of Section 90 (1) (v) of the National Health Act, is meant to serve as a price benchmark published by the Director-General in regards to services provided by the private healthcare sector. This reference list is meant to be voluntary, and thus expressly states it shall not be mandatory.

In the past two and a half years, Hasa has attempted to engage with the Department of Health on this matter, and has commissioned the services of Messer's Deloitte and Touche as independent consultants to make submissions to the Department in regards to an alternative methodology applicable to private hospitals.

The legal action initiated by Hasa against primarily the Department of Health, in February 2010, was a matter of last resort and was based on the following issues:

a) the process followed by the Department in respect of the consultation with stakeholders prior to the publication of the National Health Reference Price List for 2009 on 24 December 2008 ("the 2009 NHRPL");
b) the publication of the 2009 NHRPL; and
c) the process followed by the Department in respect of the consultation with stakeholders ahead of the publication of the National Health Reference Price List for 2010 ("the 2010 NHRPL").

Notwithstanding ample opportunity to deal with Hasa and its consultants and its representatives in numerous meetings and in a lengthy and exhaustive exchange of correspondence, the Department did not provide any meaningful or helpful input into and concerning submissions made by Hasa in both the 2009 and 2010 NHRPL processes. Despite our best efforts, we were not able to reach any conclusion in regards to any alternative methodology, and as such, the Board considered its options in regards to legal action against the Department of Health.

The case concluded in February 2010, and Hasa was granted an interim judgement against the Department, whilst the court reserved its final judgement on the matter. It is hoped however, that in the future, such action will not be necessary, and that both parties (in line with the Competition Law) can agree on a methodology which is empirically validated and relevant to the sector.

National Health Insurance

Recognising the need to improve access to healthcare, as well as develop a comprehensive strategy in regards to the financing of healthcare within the Republic, the State initiated discussion and research into the formulation of a National Health Insurance System. This arguably was as a direct result of inherent failings within the current system of healthcare delivery, as well as the public and private sector's limited ability to respond to those failings. The challenge is in establishing a universal healthcare package for all, which is both economically sustainable and appropriately financed.

Internationally, NHI models vary, although there are several similarities in how countries respond to their endemic healthcare needs. In essence, NHI is a compulsory 'medical scheme' for all working individuals, who in turn fund a subsidised healthcare system for the benefit of all. Herein lies the crunch, in that the working population of South Africa is substantially different to international models, where both employment and tax levels are higher than within the Republic. In short, South Africa faces some unique challenges in establishing NHI, and these should not be understated in the debate.

The way forward for Hasa

- Continue engaging constructively with the Department of Health and other role players;
- Provide a working platform for comprehensive public/private partnerships, founded on mutual respect and concern for the needs of the South African population;
- Provide empirical research when required, and commission additional research were the current research is either inaccurate or inadequate; and
- Have an accurate understanding of spare capacity in both the public and private hospital sector.

Hasa Commissioned Research

1. Econex

Hasa has commissioned the services of Econex to conduct research into a series of papers dealing with aspects of the National Health Insurance discussions currently underway. A series of papers, dealing with a wide range of aspects, has subsequently been published by Econex, and are available on its website at www.econex.co.za and the Hasa website www.hasa.co.za.

2. Deloittes

Hasa has commissioned Deloitte and Touche to make submission to the Department of Health in regard to the NHRPL. That submission is subject to strict competition law compliance, confidentiality agreements and authorisations as granted by the Competition of South Africa.

3. NHI Working Committee

Hasa has, together with other stakeholders, consolidated its research with additional research being conducted by other stakeholders in private health, and meets on a regular basis to share notes and findings in this regard.

PMB Task Team

The Council for Medical Schemes (CMS) issued a notice in which it noted "with concern, the industry-wide structural non-compliance with prescribed minimum benefit (PMB) provisions. These are related to: the conduct of the medical schemes; providers; and in some cases, scheme beneficiaries. These observations were made during the evaluation of compliance with administration standards and the analysis of complaints received by CMS". As a result of this, the Council undertook to:

1. Establish a PMB task team in response to feedback received on Circulars 37 of 2009, 7 of 2010, and 9 of 2010, and meetings held with industry representatives, which in turn considered the following:
   - The commercial imperatives of medical schemes;
   - Technical difficulties associated with the identification of PMB conditions; and
   - The conduct of providers who are able in certain circumstances to over-price PMB-related services.
2. These meetings concluded that all affected stakeholders, which include medical schemes and medical scheme beneficiaries, should be involved with the development of an industry-wide "memorandum of conduct" to ensure compliance with PMBs and to protect medical scheme beneficiaries.

These are some of the initiatives Hasa is extensively involved in.

Medical task team will not deal with PMB 'hot potato'

LAURA DU PREEZ: Personal Finance, 12 June 2010

Council For Medical Schemes

The medical schemes industry task team set up to address issuesaround the prescribed minimum benefits (PMBs) will not deal with the controversial issue of schemes paying for the PMBs at cost, according to the new Registrar of Medical Schemes.

The registrar, Dr Monwabisi Gantsho, put out a circular saying the task team will continue with a view to developing a code of conduct on PMB compliance, but that the interpretation of regulation eight of the Medical Schemes Act will not form part of the team's terms of reference. Regulation eight was intended to protect medical scheme members by ensuring that schemes provide certain essential healthcare benefits.

The regulation states that schemes must pay all PMB claims in full without co-payments. The Council for Medical Schemes Appeal Board has interpreted this to mean that schemes must pay in full, regardless of the rate at which a doctor or other healthcare provider charges you for a PMB.

Schemes believe the interpretation given to this regulation gives doctors and other healthcare providers a blank cheque to charge members as much as they like for PMBs, and they are concerned that this interpretation will lead to healthcare providers charging more and this will increase the schemes' costs, and thus member contributions. Last month, the Council for Medical Schemes called a workshop of stakeholders, including medical schemes, consumer groups, doctor and hospital associations, and administrators, to set up the task team. The issue of the interpretation of regulation eight was one of the main issues raised at the workshop. At that forum, Moremi Nkosi, the director of health insurance in the Department of Health, said Health Minister Dr Aaron Motsoaledi does not believe that PMBs for medical schemes should be treated as a blank cheque for healthcare providers. Nkosi said then that if the law relating to the PMBs was a problem, the new PMB task team should discuss this and how to address it. Representatives from each stakeholder group were elected to continue the task team's work and to set up its terms of reference. But late last week, a meeting of representatives elected at the workshop was abandoned when a scheme representative, Neil Nair, the principal officer of Samwumed, asked for an undertaking that regulation eight would be reviewed. When this was not forthcoming, Nair asked to temporarily withdraw to seek a mandate from schemes. The task team meeting was then abandoned, but this week Gantsho said the team will continue its work to establish a code of conduct by July 15. Gantsho said representatives on the team who wanted to withdraw from it should notify his office. Nair said he would consult with other schemes, but he believed the best way forward was to approach a court and ask it for a declaratory order on how regulation eight should be interpreted and whether it did indeed mean that schemes must pay whatever doctors charge for PMBs.

The Board of Healthcare Funders, which represents a number of schemes, has also asked its members how they wish to proceed. Gantsho said that the Council for Medical Schemes did not make the law or its regulations and did not have the authority to amend it. He said the task team was formed to deal with issues arising out of regulation eight, and many other problems with the implementation of the PMBs, and its aim was to try to resolve some of these issues by establishing a code of conduct for schemes and providers. He said that should the task team need to discuss the problems of regulation eight, it could not be prevented from doing so, but neither it nor the council itself had the authority to amend the regulation. He said the council could only, like other stakeholders, participate in a ministerial process that was considering the regulation.

Medi-Clinic Celebrates International Nurses Day

On 12 May, amid the annual Nurses Day celebrations, Gershon Jooste received the Compassion Award at Kimberley Medi-Clinic for his achievement, resilience and devotion to patients and the nursing profession.

Each year Medi-Clinic organises a formalised process to recognise the contribution of their nurse practitioners. A key element of this initiative is that all nurse practitioners are encouraged to participate in the nomination process. This nomination process concludes in a compassion winner being identified and selected at each hospital. In this way not only is the nominee recognised for his/her contribution from the management, but also acknowledged for their contributions by their peers.

Winners in each hospital receive a Compassion Award gift and certificate as well as mention in local community newspapers and in Medi-Clinic SA internal communications.

Above: Zakumi, the Fifa 2010 Soccer World Cup joined the celebrations.

Left: Nurses at Victoria Hospital in Tongaat wore their Medi-Clinic soccer shirts on International Nurses Day.

International Nurses Day at Highveld Medi-Clinic, Trichard

Best Care Always and Gauteng Collaborate on Quality Improvement

Published in Medical Chronicle

DR DENA VAN DEN BERGH, Best Care Always Chairperson

RECENTLY, ALMOST 100 DELEGATES FROM 15 HOSPITALS ATTENDED THE GAUTENG PROVINCE BEST CARE ALWAYS COLLABORATIVE QUALITY IMPROVEMENT WORKSHOP.

When Best Care Always (BCA) was launched in August 2009, the explicit goal was to create a collaborative initiative that expands the reach of quality improvement initiatives across both public and private hospitals. We were therefore very excited to have been able to host our first collaborative workshop with Gauteng.

The workshop on quality improvement was based on the founding principles of the BCA campaign which advocate that through shared learning and working together on specific areas of clinical practice, we can accelerate the pace and scale of improvement at the frontline of health-care.

The initial focus of the collaborative work between BCA and Gauteng, is on Health-care Associated Infections (HAI). This topic was identified largely because of the significant morbidity and cost burden of preventable infections and the specific evidence-based interventions that have been successful in other parts of the world, including the IHI "100K lives" campaign and Canadian "Safer Health-care Now" programme.

Prevention of infections is also one of the six focus areas of the National Department of Health's 1 000 facility, quality, and improvement initiative.

Delegates from Gauteng hospitals included professional nurses, clinical practitioners, assistant directors, infection prevention and quality assurance practitioners. These delegates were taken through the details of the four BCA Interventions (see table 1) and spent time in groups working through ways in which they could lead and

motivate staff in their units to implement all elements of the infection prevention bundles for every patient every time.

MEASUREMENT OF IMPROVEMENT

Measurement is a critical aspect of quality improvement. Within the BCA programme, participating hospitals have committed not only to implement evidence-based clinical interventions at a faster pace but also to standardise measurements, record results and report progress and success stories of the campaign. Gauteng delegates have been asked to explore both existing measures and new measures that would show that an improvement had been achieved.

A LEARNING NETWORK OF HOSPITALS

To support the effective implementation of the campaign, a formal learning collaboration has been formed with representatives from each of the 15 Gauteng hospitals. We have also committed to partnering some hospitals with mentor hospitals that have already implemented this work. This intensive, focused support ensures participating hospitals learn from one another and add to the overall learning of the campaign. The overall intervention, plus the associated process in each hospital will use the Plan, Do, Study, and Act methodology in order to facilitate an active learning approach to the work.

The BCA Gauteng quality improvement initiative is all about the power of collaboration and its potential to accelerate change and improvement by working together rather than in isolation. Importantly, the campaign is about actively improving care at the bedside through definite concrete interventions that are known to make a difference. It requires that every health professional who interacts with the patient commits to delivering a specified standard of care every time for each patient.

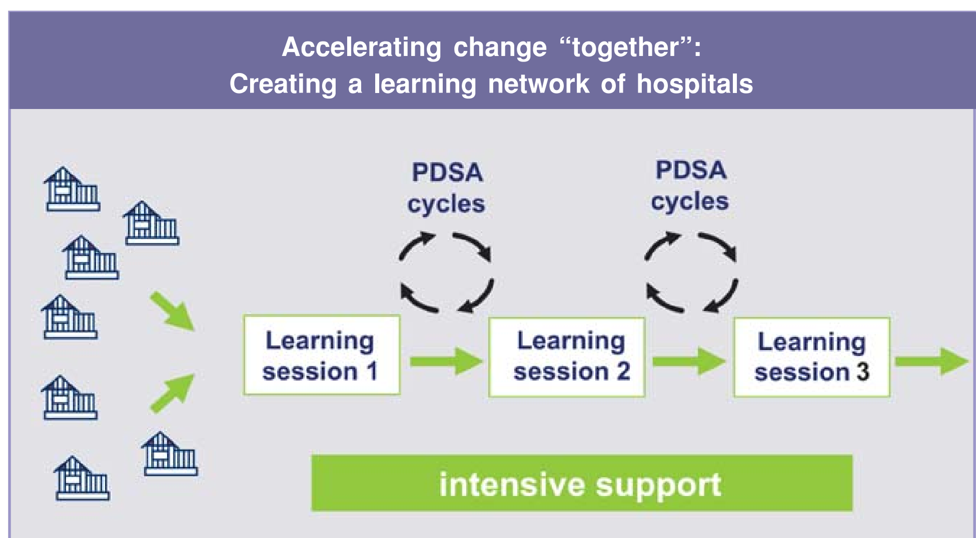
The work is made exciting because the methodology is practical and hands on and makes a difference to each patient as well as to the overall risks of healthcare associated infections. If the participation and enthusiasm demonstrated in the workshop is used as a measure, this collaborative campaign can only go from strength to strength.

For more information or to find out how you could support this work, contact Dena van den Bergh at 082 451 2284 or email info@bestcare.org.za.

TABLE 1

TABLE 1
CLI – Prevent Central Line Infections – implement a series of interdependent, scientifically grounded steps to reduce catheter-related bloodstream infections.
SSI – Prevent Surgical Site Infections – implement a series of treatment protocols to reduce the frequency of wound infections and deaths after surgery.
VAP – Prevent Ventilator-Associated Pneumonia – implement practices to prevent infections and deaths caused by pneumonia in ventilated patients.
CA UTI – Catheter Associated Urinary Tract Infections - reduce and ultimately prevent cases of symptomatic catheter-associated urinary tract infections.

Accelerating change "together": Creating a learning network of hospitals



HEALTH AWARENESS

JULY
Mental Illness Awareness Month

AUGUST
Organ Donor Month

- 1 - 7 World Breastfeeding Week
- 2 - 8 National Immunisation Awareness Week
- 2 - 6 Rheumatic Fever Week
- 24 - 31 African Traditional Medicine Week
- 31 African Traditional Medicine Day

LEGAL WATCH

Adv Kurt Worrall-Clare, Hasa CEO

The National Health Act, 2003

Sections 55 and 56 of the National Health Act, relating to the removal of blood or other tissue, together with Section 68 which permits the Minister of Health to make regulations relating to tissue, cells, organs, blood, blood products and gametes, has been promulgated. (In other words, has become law, as of 17 May 2010). See at this web address: http://www.info.gov.za/view/DownloadFileAction?id=122568

Removal of tissue, blood, blood products or gametes from living persons

55. A person may not remove tissue, blood, a blood product or gametes from the body of another living person for the purpose referred to in section 56 unless it is done:

(a) with the written consent of the person from whom the tissue, blood, blood product or gametes are removed granted in the prescribed manner; and

(b) in accordance with prescribed conditions.

Use of tissue, blood, blood products or gametes removed or withdrawn from living persons

56. (1) A person may use tissue or gametes removed or blood or a blood product withdrawn from a living person only for such medical or dental purposes as may be prescribed.

(2) (a) Subject to paragraph (b), the following tissue, blood, blood_products or gametes may not be removed or withdrawn from a living person for any purpose contemplated in subsection (1):

(i) Tissue, blood, a blood product or a gamete from a person who is mentally ill within the meaning of the Mental Health Care Act, 2002 (Act No. 17 of 2002);

(ii) tissue which is not replaceable by natural process;

(iii) a gamete from a person younger than 18 years; or

(iv) placenta, embryonic or foetal tissue, stem cells and umbilical cord, excluding umbilical cord progenitor cells.

(b) The minister may authorise the removal or withdrawal of tissue, blood, a blood product or gametes contemplated in paragraph (a) and may impose any condition which may be necessary in respect of such removal or withdrawal.

The Minister of Health has also, in terms of the National Health Act, promulgated regulations pertaining to the withdrawal of blood from a living person for testing.

Copies of the regulations are available from Hasa or at the following web address:http://www.info.gov.za/view/DownloadFileAction?id=122555

Doctors face more claims over mistakes

SLINDILE KHANYILE:
Business Report, 17 June 2010

An increasing number of claims were being lodged against medical practitioners in both the public and private sectors, according to the Health Professions Council of SA (HPCSA) and the Medical Protection Society (MPS). The MPS, which represents doctors in the private sector only, said there were currently more than 800 active claims against doctors and about 1 000 reported matters that could become claims in the future. Last month, the *Sunday Independent* reported that doctors in public hospitals cost taxpayers more than R1 billion in lawsuits because of botched operations. Marella O' Reilly, the acting registrar and chief executive at the HPCSA, said that of the approximately 2 700 complaints received on an annual basis, this figure still remained very little if one calculated the number of services rendered by the country's 180 000 registered healthcare practitioners on a daily basis. In the 2009/10 financial year, the HPCSA finalised 199 matters, which included fines, acquittals, suspensions, erasures, caution and reprimands, defence objections upheld and matters referred to preliminary inquiry committee for noting. Ronald Bobroff, a medical malpractice specialist, said the biggest challenge was finding medical experts who were prepared to give evidence against other practitioners. The cases generally took three years to settle in court, he added.

LEGAL developments

By Donald Dinnie at Deneys Reitz

There are a number of legal developments both local and international which may be of interest to Hasa members.

- In Tabet v Gett [2010] HCA 12, a decision of the High Court of Australia, held that damages are not available for loss of chance of a better medical outcome unless it can be proven on a balance of probabilities that the patient would have had a better outcome had the Defendant not been negligent. That judgment also re-affirmed that the standard of proof in negligence actions is on a balance of probabilities.
- Gazettes received on 9 April 2010:
  - Children's Act 33 of 1960 – Repealed by Children's Act 38 of 2005 with effect from 1 April 2010.
  - Children's Act 38 of 2005 - Commencement of the remaining sections of the Act with effect from 1 April 2010 - Proc. R12 / GG 33076 / 20100401.
- Gazettes received on 16 April 2010:
  - **Medicines and Related Substances Act 101/1965):** Declaration of medicine as undesirable: Withdrawal notice.
  - **Medicines and Related Substances Act 101 OF 1965:** Information to be furnished by manufacturers and importers of medicines and scheduled substances before applying an increase to the single exit price - GN 290 / GG 33110 / 20100413.
  - **National Environmental Management: Air Quality Act 39 OF 2004:** List of activities which result in atmospheric emissions which have or may have a significant detrimental effect on the environment, including health, social conditions, economic conditions, ecological conditions or cultural heritage. Added by GN 248 / GG 33064 / 20100331 with effect from 1 April 2010.
- **National Health Act 61 of 2003;** Proposed regulations relating to communicable diseases - GN 287 / GG 33107 / 20100413. The regulations establish a Communicable Diseases Advisory Committee. The members are to be appointed by the Minister of Health. The regulations also outline the fields of expertise from which committee members are to be drawn. The objectives of the committee are prescribed. Amongst others, the committee is expected to advise the minister on the control of communicable diseases, how information on communicable diseases can best be managed, propose ways to strengthen the surveillance of such diseases and undertake a review of the list of priority communicable diseases. The regulations also set out the responsibilities of the national health department in terms of communicable diseases. Responsibilities assigned to the provincial and local government spheres are also laid down. The regulations prescribe how notifiable communicable diseases are to be declared. The prevention and control of communicable diseases by health authorities and heads of institutions is also explained. The proposed regulations also set out on what grounds mandatory medical examinations, isolation and quarantine can be imposed.
  The regulations contain a list of priority communicable diseases.
- **Health: Budget vote speech:**
  The Department of Health intends tabling the National Health Amendment Bill in Parliament in 2010.
  This was revealed by the Minister of Health, Dr Aaron Motsoaledi, during his budget vote speech in the national assembly. According to the Minister of Health, the bill will provide for a review of the powers and functions of both the national and provincial departments of health. The proposed legislation will also seek to bring about the establishment of an independent office of standards compliance and allow for a review of the current position on the licensing of blood transfusion services. The department hopes to table the bill in September 2010. This bill will cover "all important amendments to all acts administered by the national department of health, to ensure that existing legislation enable(s) us to implement government's priorities, where it is found to be inconsistent with these policies".
- **In McDonald v Wroe** [2006] 3 ALL SA 565 (C), the plaintiff claimed in delict for damages arising from a dentist's alleged failure to warn the patient of the material risk attached to the operation. The court found that that failure was causally linked to the damage which was suffered and that delictual liability was established. The court confirmed the test for the duty to warn and informed consent as established by the court in Castell v De Greef [1994] 4 SA 408 (C).
  - The Council for Medical Schemes Levies Act 58 of 2000 has proposed levies on medical schemes published for representations (GenN 244 in GG 33025 of March 2010).
  - Sibaya v The Professional Conduct Committee of the South African Nursing Council 2006 JDR 0974(T) dealt with the review of finding and penalty of the Nursing Council in respect of conduct of the appellant sister. The judgement turns in part on procedural issues including the

continued on page 10

Nurses can also manage HIV treatment

TAMAR KAHN: Business Day, 18 June 2010

Nurses do as good a job as doctors do at monitoring patients on HIV/AIDS drugs. A new study shows, lending weight to a recent government decision to introduce "task-shifting" to try to meet its ambitious treatment targets. South Africa has the world's largest number of people infected with HIV, and until recently only a doctor could initiate and manage patients' treatment. But with too few doctors on hand, the government is looking to nurses to help. In April it introduced a new policy allowing suitably qualified nurses to prescribe antiretroviral medicines and manage patients, with backup from more specialised doctors for complicated cases. Although there is growing acceptance for task-shifting, which is the policy of the World Health Organisation, to date there has been little research to back it up. A new study, published this week in The Lancet, shows nurse-monitored care can be just as safe and effective as therapy overseen by doctors. Scientists from the Comprehensive International Programme for Research in AIDS in SA randomly assigned 812 HIV patients to two groups – 408 managed by nurses, and other 404 by doctors. The patients were started on treatment by doctors, as at the time nurses were not permitted to prescribe antiretrovirals. Volunteers were recruited at clinics in Masiphumelele in Cape Town and Soweto, Johannesburg. Acutely ill patients were excluded from the study. After two years, the number of deaths and the number of patients who needed to switch medicines due to side-effects was found to be the same. A total of 192 patients (48%) experienced treatment failure in the nurse group and 179 (44%) in the doctor group. There were ten deaths in the nurse group, and eleven in the doctor group. The study's principal investigator, Prof Ian Sanne, said the reach of the paper was global - it demonstrated the non-inferiority of nurse-led care. He said the concern that patients would be less well monitored had not transpired and as treatment options got better, monitoring patients by nurses would get even easier.

continued from page 9

sister's delay in launching the review. In dealing with part of the merits of the claim, the judgement is useful in that the court held on the facts:

- All that was required of the sister was not an extraordinary duty as a mid-wife but rather to request the intervention of another doctor when it was clear that the attending doctor's views and instructions were not in accordance with the patient's condition and records.
- Work pressure and lack of resources cannot be an excuse for failure to keep proper records. Good and proper record-keeping serve the purpose of proving the actions taken by the specific midwife.
- Four years experience as a midwife does not render that person relatively new in the profession and a first offender. A midwife with four years experience is not relatively new in the nursing profession and lack of experience cannot be an excuse for the death of the baby which occurred.

■ The South Gauteng High Court in M J van der Merwe v The Premier of Gauteng in a recent judgement was faced with the question whether the relevant provincial hospital and its doctors had been in breach of contract by negligently failing to treat the plaintiff within the first six hours of injury to his finger resulting in amputation of his right finger.

The court found that if the plaintiff's finger could have undergone surgery within six hours of the injury there was a chance that the finger could have been saved. That operation could not be performed within the relevant time period and the hospital's medical personnel at the relevant hospital and available theatres did not render it possible to perform the operation within that period. He was not informed that if he wanted such an operation, he should consider going to other hospitals nearby.

The Court accepted that the proposed revascularisation procedure was a daunting task and not attempted in South Africa, but, if the plaintiff had been informed about it at the hospital, he could have made alternative arrangements. The plaintiff had to wait in eleven hours before being operated on which the court found totally unacceptable under the circumstances.

The court said that there was no onus on the plaintiff to prove that there were hospitals in the vicinity with theatre facilities to take him. That would be "*tantamount to placing an onerous duty on the plaintiff*".

The court found that, if it was not possible for the provincial hospital to have treated the plaintiff within the six golden hours required, they should have advised him that he can make an election. The attending doctor was informed and knew that the plaintiff's medical condition required immediate attention. To make the plaintiff wait eleven hours before surgery was not the conduct of a reasonable practitioner and constituted negligence.

The judgement follows that of the unreported judgment of Bunge N.O v MEC for Health Kwa-Zulu & Others of 8 October 2009 to the effect that hospitals and doctors are obliged to warn a patient of the seriousness and potential consequences of the patient's condition. If they are unable to perform the diagnosis and care, they should advise the patient accordingly.

Hasa members who want copies of the judgments or regulations referred to, can contact Donald Dinnie at DD@deneysreitz.co.za.

Is there a doctor IN THE HOUSE?

Competition for high-level skills was always going to be a major factor in a globalised economy. One in five African-trained doctors is practicing abroad. Table 1 highlights the exodus of medical personnel from Africa, a region struggling with a health crisis. The Centre for Global Development study used census data on arriving African health professionals to nine major destinations and concluded that the numbers have increased since they last carried out the survey between 1999 and 2001. The same survey found that SA had lost more than half (21%) of the healthcare skills it attracts from other countries.[1]

Like the rest of Africa, the South African healthcare sector is haemorrhaging skills. In South Africa there are more than 4 000 doctor vacancies in the public sector. Gilson and McIntyre concludes that, despite policy efforts, inequities in healthcare access remain and exacerbating underlying challenges such as poor perceptions regarding the quality of publicly provided healthcare and the influence of insurance status on utilization patterns.[2] Even more depressing is there egregious divide between the Rural and Urban sectors.

In March 2008 Mpumalanga had a doctor vacancy rate of 54% significantly higher than the national average of 37%.[3] Despite having the largest health professional production capacity in Africa, SA has ended up with a massive shortage of clinical staff in the public sector and an even direr need in rural areas. Meanwhile demands on the healthcare system are rapidly escalating because of the quadruple burden of diseases plaguing the country.

This shortage of skills adds a cost burden on private healthcare. Mike Schüssler, in his analysis of private hospitals expenditure and revenue, reported that staff alone accounts for more than 70% of private hospital's expenditure. Professional fees have increased with more than 125% from 2000 to 2006.[4]

For a large country with poor neighbours, SA is also fairing badly with respect to training. For comparative purposes all eight SA medical universities take in a total of 1 250 students each year. These numbers do little to absorb the impact of the brain drain observed overtime. In the last 15 years, SA medical schools produced approximately 19 500 graduates but registered doctors only increased by 9 304.[5] The rest are working elsewhere.

Endnotes

1 Clemens, MA and Gunilla, P. (2007) New data on African health professionals abroad. Centre for Global Development, Working Paper No. 95, February 2007
2 Gilson, L. and McIntyre, D.(2007) Post-apartheid challenges: household access and use of care. International Journal of Health Services 37(4): 673-691
3 Mahlalela, F (2008). 2008/09 Policy and Budget Vote Speech, 13 June 2008.
4 Mike Schussler (2008). Hasa Annals, 2008
5 Paton, C. Terminally Ill. Financial Mail, Johannesburg, 14 April 2006
6 PERSAL, 2003

TABLE 1: NUMBER OF AFRICAN-TRAINED DOCTORS ABROAD

Sending country	*Domestic**	UK	USA	France	Canada	Australia	Portugal	Spain	South Africa	Total abroad	Frac.**
Botswana	530	28	10	0	0	3	0	0	26	68	11%
Egypt	143 555	1 465	3 830	471	750	535	1	17	19	7 119	5%
Ghana	1 294	590	850	16	95	0	0	4	82	1 639	56%
Mozambique	435	16	20	0	10	3	1,218	4	61	1 334	75%
Namibia	466	37	15	0	30	9	0	0	291	382	45%
Nigeria	30 885	1 997	2 510	29	120	0	1	13	180	4 856	14%
Senegal	640	0	40	603	10	0	1	9	3	678	51%
South Africa	27 551	3 509	1 950	16	1 545	1 111	61	5	-834†	7 363	21%
Swaziland	133	4	4	0	0	0	1	0	44	53	28%
Zambia	670	465	130	0	40	39	3	0	203	883	57%
Zimbabwe	1 530	553	235	0	55	97	12	1	643	1 602	51%
Africa	*280 808*	*15 258*	*12 813*	*23 494*	*3 715*	*2 140*	*3 859*	*1 096*	*1 459*	*64 941*	*19%*
Sub-Saharan	*96 405*	*13 350*	*8 558*	*4 199*	*2 800*	*1 596*	*3 847*	*173*	*1 434*	*36 653*	*28%*

Source: Centre for Global Development, 2007

DOCTORS' CHAMPION

JACQUI PILE: The Financial Mail, 18 June 2010

Government's latest pay offer to certain public sector doctors and specialists, with an annual increase of 1,5%-3%, has shocked Phophi Ramathuba, chair of the public sector doctors' committee of the SA Medical Association (Sama).

Feisty, dedicated and approachable, Ramathuba considers herself an activist for better conditions for public sector doctors. She was vice-president of the student representative council at Medunsa, where she completed her medical degree. But it was her training at a rural hospital during her community service that made her passionate about the public sector, to ensure ordinary citizens get access to health professionals.

"But I realised if I stayed in the public sector, I was going to fight," said Ramathuba, who is now chief medical officer at Voortrekker Hospital in Mokopane.

Top of her list of priorities at Sama, is getting government to negotiate with doctors and specialists separately from other public sector health workers on issues that affect them specifically.

Last year Sama won an important battle for an occupation-specific dispensation (OSD) - the idea being to retain doctors and attract new ones to public health. State budget constraints meant, however, that Sama secured only a 50% increase for interns, principals and chief specialists and an agreement with government to negotiate junior specialist and medical officer salaries this year.

"There has been an exodus of doctors from the public sector, yet government seems unwilling to attract doctors or retain them."

Phophi Ramathuba,

"The OSD talks involved various professions engaging simultaneously, sometimes against each other and at cross purposes. This resulted in government giving us a lower offer and fellow unions accepting it against our express wish," said Ramathuba.

"Unions with a critical mass of numbers were listened to, but doctors would never be able to gain the critical mass needed to achieve full status in the bargaining chamber. This is a problem exacerbated by the 35% vacancy rate in state hospitals for doctors and specialists. The time has come for doctors to be allowed their own bargaining chamber to negotiate more successfully and equitably," continued Ramathuba.

Ramathuba, who also has a master's degree in pharmacology from the University of Pretoria, and an advanced post-graduate degree in health management from Manchester Business School, said government's mooted national health insurance system could improve access to healthcare, but this depends on the improvement of public sector hospitals.

"When babies die in public sector hospitals, politicians are quick to blame the doctors and nurses, when hospital management is really at fault. The main problem is that hospital managers are political appointments and in many cases are not even healthcare professionals."

Ramathuba has worked in various branches of Sama. She was a member of Sama's Junior Doctors' Association before becoming chair of the Senior Hospital Doctors' Association, also a Sama branch. In her current role, she represents doctors and specialists across the public sector. Says Ramathuba: "I can either watch people die or do something about it."

NEWS IN BRIEF

MORE THAN HALF OF THE 1 754 foreign-qualified doctors who registered over the past six years to practise in South Africa, come from other African countries. According to a written reply by Health Minister Aaron Motsoaledi to a parliamentary question, about 950 African doctors registered with the Health Professions Council of SA from 2004 to 2009. Of these, 336 were from Nigeria, 191 from the Democratic Republic of Congo, and 182 from Zaire. Doctors who had registered from other parts of the world included 193 from Britain, 83 from Cuba, and 38 from India.

HEALTH EXPERTS SAY THE SOCCER World Cup's positive lifestyle message is undermined by the choice of junk food giants as sponsors. The tie-ups with McDonald's, Coca Cola and Budweiser are worth hundreds of millions of dollars to Fifa, and some of that cash is to be invested in grassroots sports projects. But nutritionists worry that youngsters are particularly vulnerable to the association of their sporting heroes to food and drinks high in fats and sugar. A recent report by the national Heart Foundation, found that 29 percent of South African men and 56 percent of women are overweight. About 17 percent of children aged between one and nine are also classed as overweight. According to Thami Bolani, Chairman of the National Consumer Forum, the tournament would have been the "perfect opportunity to educate all communities about healthy eating, but we missed the boat on this one completely".

DEAL GIVES ADCOCK US FIRM'S LOCAL DISTRIBUTION

Adcock Ingram has entered into a five-year deal to co-promote and distribute Merck & Co's over-the-counter medicines and a selection of prescription medicines that are registered in South Africa. Merck, known as MSD outside the US and Canada, said the deal formed part of its long-term strategy to expand in emerging markets. Though the financial effects of the transaction at this stage will not be material, it should go a long way in helping the country's second-largest pharmaceutical firm to grow, as it will enhance its diverse portfolio and broaden its pipeline of new products in the market place. Jonathan Louw, the chief executive of Adcock, said working with MSD would also boost their

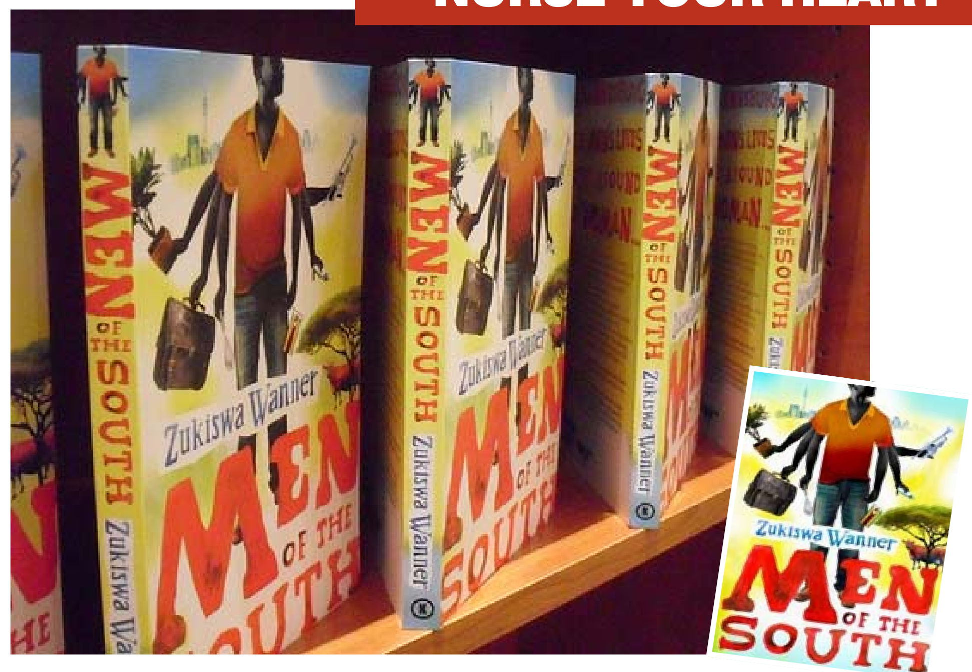
credibility. He said the collaboration was strategically important for Adcock, adding that the partnership was in key areas where it already had strength, which would enhance MSD's ability to sell more products. Louw said the two companies had worked together in SA for several years, as Adcock Ingram had been marketing Organon Bioscience's women's healthcare products since 2005. Organon was acquired by Schering-Plough in 2007, prior to Merck's merger with Schering-Plough last year. The products that will form part of the deal are for various therapeutic areas such as cardiovascular, women's health and asthma. These are drugs such as Renitec for hypertension, Zocor for cholesterol, Singulair for asthma, Maxalt for migraines and over-the-counter products including Demazin, Drixine and Tinaderm. Adcock's business comprises pharmaceuticals and hospital products. It has a ten percent market share in the local private pharmaceutical space. Stefan Oschmann, the president for emerging markets at MSD, said the collaboration was significant for the New York-listed firm because it was part of their growth strategy in these markets. He said that most pharmaceutical firms were shifting towards the so-called emerging markets because 90% of world pharmaceutical growth between 2010 and 2015 would be driven by emerging markets. Dr Oschmann said the agreement with Adcock Ingram was the first of its kind for Merck, and that the company was pursuing similar deals in other emerging markets, which include Asia Pacific, China, Latin America, Brazil, Eastern Europe, the Middle East and Africa. He declined to provide further details regarding the companies or territories being explored. Last month, Adcock said it was planning to generate 30% of its revenue from outside of Africa within the next three years. Lizelle Wentzel, the healthcare programme manager at Frost & Sullivan, said it would appear that MSD would gain the largest short-term benefit. She said Adcock Ingram was a well-recognised brand among the average consumer so there would seem to be a clear advantage to MSD in leveraging off that brand. She said that there might also be a longer-term component for MSD, as it could be considering a future scenario in which products coming off patent could be manufactured as generics under licence with Adcock. Wentzel said there were no obvious short-term benefits for Adcock, but said the company was probably thinking about the future and considering their need to build an international brand. Abdul Davids, an analyst at Kagiso Asset Management, said such partnerships were good because they are less risky compared to acquisitions. He said they provided immediate value, and enhanced profitability without a company having to sacrifice earnings or taking up debt for an acquisition. He pointed out that Aspen Pharma-care, South Africa's biggest generics manufacturer, has benefited handsomely out of its relationship with British multinational GlaxoSmithKline. In the year ended September, Adcock generated a turnover of R4.1 billion while net profit for the period was R789.8 million. MSD's worldwide sales for the year ended December were \$27.4 billion (R209 billion) while net income was \$12.8 billion.

NURSE YOUR HEART

Novel: Men of the South

Author: Zukiswa Wanner

Hasa verdict: A veritable page turner



Zukiswa Wanner's latest offering, *Men of the South,* is none other than brilliant. The pages are breathtakingly tickling pink, unlike her two previous novels, *The Madams* and *Behind Every Successful Women,* this page turner has nothing to do with women. In *Men of the South* Wanner's song-like prose is about men, or rather what makes men's cheeks run wet with tears. *Men of the South* navigates the complex lives of ordinary people in a beautiful story that explodes into three worlds peppered with xenophobia and homophobia. Mzi may not believe that one can be 100% of anything, but he completes Wanner's lively and joyful narration as she takes readers through the story of deceit, love and quiet vengeance. Wanner's mellowed story-telling morphs from a documentary of vivid characters working the streets of Johannesburg into a psychosocial tome of the idiosyncrasies of big town lifestyles which give the novel a vibrant physicality of a metropolis that transcends simple families. After her two previous novels, largely reviewed as chick-lit (literature for chicks), it was high time South African-based Wanner, born in Zambia, lived in Zimbabwe, and studied in the United States, put down something that navigates the apologetic lives of the different shades of people that try to eke out a living in a post-apartheid South Africa. Nonetheless, the brilliance of Wanner is her ability to create easily recognisable characters. Many big city dwellers will identify and interact with Mfundo's (a penniless musician and father) trials with an annoying but bread-winning partner, as well as Tinyae's (a Zimbabwean refugee) tribulations in a South Africa that does not recognise that one can be both Zimbabwean and skilled.

Don't miss out...

on your chance to feature in this year's Health Annals.

Preparations for Hasa's annual research-driven publication, are well under way. **So, contact us now** to book prime advertising space or to update your hospital, clinic or medical scheme's vital statistics.

Contact Dawn Adams
tel: 011 478 0156 or email:
contact@hasanet.co.za

For the latest healthcare information