



Health financing inequities spelt out in Health Charter

Latest figures indicate that the state spends some R33.2 billion on healthcare for 38 million people.

"The private sector spends some R43 billion servicing seven million people," Minister of Health, Dr Manto Tshabalala-Msimang added when presenting the draft Health Charter to interested parties in mid-July.

She also made the point that about 39% of total health care funds in South Africa flow through the public sector financing intermediaries (primarily the national, provincial and local departments of health). About 60% is channeled through private intermediaries.

Here she noted that medical schemes are the single largest financing intermediary - accounting for nearly 47% of all healthcare expenditure - followed by the provincial health departments at 33% and households (in terms of out-of-pocket payments directly to health care providers) at 14% of all healthcare expenditure. From this the minister concluded that the financing of healthcare in South Africa currently contributes to the inequity between the public and private health sectors.

"The draft Health Charter we are presenting today," Dr Tshabalala-Msimang continued, "calls upon the public and private health sectors to constructively engage in dialogue and discussion on health matters. It acknowledges the stewardship role of government and equally emphasizes that the interests and views of the private sector should be taken into consideration when introducing legislative and other reform for the rational and equitable distribution of health services."

Black ownership should exceed 50% in 10 years

The draft Health Charter presented by the Minister of Health in July proposes that each firm or business in the healthcare sector be at least 26% owned and/or controlled by black people.

"This process should commence immediately," said Dr Manto Tshabalala-Msimang, adding that by 2010, each business in the healthcare sector should at least be 35% owned or controlled by black people.

Equity ownership by black people, she said, should increase to 51% by 2014.

The minister went on to explain that regulations will be developed under the National Health Act that facilitates Broad-Based Black Economic Empowerment. Procurement policies and processes that are favourable to firms owned or controlled by black people, will be implemented.

Areas earmarked for "special focus", she said, would be:

- hospitality services and general procurement
- pharmaceutical products and medicines
- medical equipment
- professional services
- IT systems
- distribution and wholesaling services

"At least 60% of all procurement shall be from black owned firms or black persons by 2010. By 2014 this should increase to 80%," she concluded.

Generics contribute to drop in medicines expenditure

A 14% increase in generic medicines utilisation between 2003 and 2004 has been one of the main contributing factors towards a total 21% drop in medicines expenditure during the same period according to the recently released Mediscor Medicines Review 2005.

Based on processed claims on the Mediscor database from general practitioners, medical specialists, community pharmacies, courier pharmacies and other provider groups such as hospitals and homeopaths, the Review has revealed that GPs had the highest generic medicines utilisation rate at 58,7%. They were followed by community pharmacies (35,4%) and courier pharmacies (38,3%).

The highest average cost per item, however, was reflected in the courier pharmacy data because of the nature of the products dispensed such as chronic medications. Many courier pharmacies, the Review points out, are also preferred providers for certain expensive therapies.

The drop in medicines expenditure could also be attributed to the introduction of the single exit price (SEP) and dispensing fees as well as legislation against discounting.

The highest number of claims submitted (72,8%) came from community pharmacies. GPs followed at 32,6% and then the courier pharmacies at 5,5%.

Only private sector will benefit from health tax - Cosatu

The Congress of South African Trade Unions (Cosatu) rejects the position that taxation should be increased to force workers into medical schemes, Rudi Dicks, labour policy co-ordinator, stressed at the recent Board of Healthcare Funders Conference.

Referring to the proposed Social Health Insurance SHI tax subsidy, or "payroll tax", Dicks said that this would only result in more money being turned over in the private sector instead of improving public healthcare. The government, he added, must improve resources for public health and "not push people into the private sector".

Emergency medicine treatment uncertainties addressed

The Hospital Association of South Africa (Hasa) has compiled a *Recommended Emergency Treatment Policy for Private Hospitals* policy document for use as a guiding protocol by its members.

"The single most important purpose of this document is to address the vacuum in South Africa's current legislation regarding the definition of emergency medicine," originator of the guideline, HASA acting CEO, Adv Worrall-Clare, said when introducing the document in late June.

He pointed out that Section 27 of the Constitution of the Republic of South Africa (the Constitution) stipulated that "no one may be refused emergency medical treatment", the Ethical Rules of the Health Professions Council of SA (HPCSA) stating that "no practitioner may refuse to treat a patient in an emergency", and Section 5 of the National Health Act ruling that "a healthcare provider, healthcare worker or health establishment may not refuse a person emergency medical treatment."

The exact definition of a medical emergency, Worrall-Clare noted, was still unclear – hence the decision to produce the guideline: "The protocol we have developed defines emergency medical conditions, emergency medical treatment, and the roles and responsibilities of the various players; right down to the matter of obtaining informed consent prior to the provision of medical treatment."

The document also details guidelines for triage or medical screening by a trained healthcare professional to determine whether or not the patient is presenting with an emergency medical condition; the appropriate resuscitation, stabilisation and monitoring interventions in the event of an emergency; and the conditions under which patients may be transferred to alternative healthcare establishments.

PMB costs must be reduced for low income segment

A ministerial task team appointed to investigate low cost benefit options has already reached consensus that Prescribed Minimum Benefit (PMB) costs will have to be reduced to accommodate the low income segment of the market.

The team, led by Dr Jonathan Broomberg (Discovery Health), will be submitting its report to the minister in November and low cost policy option recommendations are scheduled to be released in April 2006. Implementation of the resulting low cost option products is intended to take place in January 2007.

Speaking to delegates to the recent Board of Healthcare Funders (BHF) Conference at Sun City, Broomberg said that existing low income schemes/options had had limited success in extending coverage. He said that 3 000 000 lives had joined 'low cost schemes/options' over the past six to seven years. Only 40% of these had been newly-covered lives, the balance being "buy downs".

He added that in terms of the policy proposals, households in the R2000 to R6000 income range would be targeted.

On the subject of PMBs, he said that the preferred approach would be to develop two or more modular PMBs, i.e. "out-of-hospital" and "hospital". Each module would have minimum benefits and options which, he explained, could be designed around any single module or combinations.

Doctors urged to follow Council's HIV/Aids guidelines

The Health Professions Council of South Africa (HPCSA) has issued a statement urging doctors to follow the guidelines the Council provides for the treatment of HIV/Aids patients.

"These guidelines form the ethical basis of any disciplinary action we might take against a health care practitioner should a patient report unprofessional conduct to us," HPCSA Registrar, Adv. Boyce Mkhize, notes in the statement.

Released primarily to announce that the HPCSA has embarked on an initiative to fast track complaints from members of the public regarding the way some health care practitioners handle HIV/Aids related issues, the Council explains that complaints range from breach of contract of confidentiality on the part of a health care practitioner, failure to provide HIV test counselling to failure to treat patients due to their HIV status.

"Previously such complaints were dealt with in terms of the Council's normal disciplinary processes," the statement adds, "and some complaints had to be shelved after complainants passed away without testifying. Following such incidents, the Council has vowed all related complaints will be given special attention and speedily processed due to the sensitivity and seriousness of such issues."

The HPCSA notes that it has finalised a number of cases in the past few months, conceding, however, that some of these dated back to 1999.

Health tax pegged at 4,5% not a certainty

Prof Heather McLeod, chairman of the Risk Equalisation Technical Advisory Panel (RETAP) and the Council for Medical Schemes' REF co-ordinator, intimated at the BHF Conference that the proposed Social Health Insurance-linked tax would not necessarily be pegged at 4,5% as generally believed.

Prof McLeod's comments followed Cosatu labour policy co-ordinator, Rudi Dicks' assertion that the new tax would raise the healthcare expenditure of people earning between R3000,00 and R4500,00 from 1% to 4,5% of their income.

McLeod pointed out that the tax amount involved would depend on what benefits would be equalised in terms of the Risk Equalisation Fund, the level of SHI subsidies and how many people the SHI system would be covering.