NEWS

SUBSTITUTION OF DOCTORS BY NURSES IN PRIMARY CARE

Demand for primary care services has increased in many countries owing to population ageing, rising patient expectations, and reforms that shift care from hospitals to the community. At the same time, the supply of physicians is constrained and there is increasing pressure to contain costs. Shifting care from physicians to nurses is one possible response to these challenges, with the expectation that such substitution would reduce cost and physician work load while maintaining quality of care.

In a Cochrane review of 16 studies in which the nurse took responsibility for first patient contact and/or ongoing care,[1] it was found that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes and levels of patient satisfaction. However, there may not be reductions in cost or physician work load and these depend on the particular context of care.

In some studies there was clear evidence that nurses tended to spend longer with the patients, gave more information and recalled patients more frequently than did doctors. This suggests that, while the cost of training and employing nurses is less than for doctors, the overall cost of providing care remains about the same. Doctors' work load may remain unchanged either because nurses are deployed to meet previously unmet patient need or because nurses generate demand for care where previously there was none.

In this context, nurse substitution refers to the provision of services which otherwise would be provided by doctors alone (as distinct from a nurse supplementation, where nurses provide services which complement or extend those provided by doctors).

Source: **www.cochrane.org**

1. Laurant M, *et al.*. Substitution of doctors by nurses in primary care. *The Cochrane Database of Systematic Reviews 2004*, Issue 4. Art. No.: CD001271. DOI: 10.1002/14651858. CD001271.pub2.

NETCARE ANNOUNCES R1 BILLION BEE DEAL

Netcare has announced a R1 billion deal in terms of which 10% of its ownership will be acquired by broad-based empowerment groupings by 1 October 2005.

As part of its 'Health Partners for Life' Netcare will facilitate the equity acquisition with the formation of several trusts comprising historically disadvantaged beneficiaries. These are:

- Mother & Child Trust (MCT), comprising women and children, which will acquire a 7.5% allocation (value approximately R75 million).
- Healthy Lifestyle Trust (HLT), which will promote a healthy lifestyle through wellness programmes and national screening initiatives and will acquire a 5% allocation (approximately R50 million).
- Patient Care Trust (PCT), comprising nurses and caregivers within Netcare, which will acquire a 37.5% allocation (approximately R375 million).
- Passionate People Trust (NPT), comprising management and staff of Netcare, which will acquire a 20% allocation (approximately R200 million).
- Physician Partnerships Trust (PPT), comprising doctors within Netcare and Netpartner as well as the public sector, private sector and medical schools, which will acquire a 30% allocation (approximately R300 million).

Jackie Shevel, CEO of Netcare, says that the deal will take Netcare's BEE shareholding to over 25%, with the strategic advantage of having management, staff, health care professionals and a broad-based empowerment grouping ultimately owning more than 30% of the group.

Source: **www.netcare.co.za**

MEDICAL AID SCHEMES – GUARDING THE GUARDIANS

Leading the discussion at Mx Health's April Quarterly Health Review, David Sullivan of Radio 702 wondered whether his role would be that of chair – or boxing referee. 'If there's one topic that will keep the lines of Radio 702 jammed, it's a health issue – especially medical aid schemes.'

Seven key players in the health care industry were asked to comment on the following:

- Is the vision embodied in the Medical Schemes Act of 1998 and the Medical Schemes Amendment Bill of 2001 being realised?
- Have trustees become the guardians of the medical schemes' public?
- How well equipped are they to fulfil this task?
- How independent are they of role players such as brokers and administrators?

Independence of trustees

Alex van der Heever, advisor to the Registrar of Medical Schemes, sees this as a process which is moving forward. 'Before 2000, it was often the case that the directors of administration companies were sitting as trustees of medical scheme as well. Conflicts of interest were rife. The issue we faced was how to reduce conflicts of interest and improve the requirements made of trustees.'

There was general agreement that to a large extent this has

happened. Trustees have begun to act independently and use their powers. 'The industry has really shifted,' said Kirsten Nematandani, chairman of Hosmed. 'More trustees are taking decisions and challenging the status quo.'

Member participation

Nevertheless there are still examples of weak democratisation, commented Van der Heever. 'We need to ask if this is a structural issue which must be addressed in terms of a framework that will remove obstacles to participation, for example in AGMs.'

Some of these obstacles might be holding AGMs at inaccessible venues, at times when it is hard for members to attend, and with inadequate notice.

Member participation was seen as one way of reducing the bias on boards, as well as providing checks and balances. However, said Jimmy Mahlala, trustee and previously chairman of Bonitas Medical Scheme, electing trustees from a group with little understanding of or exposure to the industry could select against a board with the appropriate competencies.

Training and support

Qualifications of and support for trustees were seen as crucial. Training for trustees is available from the Council for Medical Schemes, but it is not mandatory, and this was a concern for panellists. It was suggested that certain basic training should be compulsory, and that training should be continuous rather than once-off.

The fact that trustees almost invariably have another, full-time job was raised. 'One major problem is that, for the trustees, this is a part-time job,' said Emile Stipp of Deloittes. 'Do they really have the time to deal with it?'

Jeremy Yatt, chief executive officer, Fedhealth, said that in order to encourage involvement by a high calibre of person, it is necessary to create a rewarding environment.

Questions were asked about the clout that trustees have. 'They have a great deal of power,' said Van der Heever. Charles Wells, deputy chairman, Bankmed Board of Trustees, agreed, adding that at Bankmed the trustees had used their power to bring in a corporate governance policy and create transformation. However, other panellists pointed out that it is hard to exercise powers when you are new to a role or up against powerful lobbies or voting groups.

The principal officer

'The principal officer sometimes has too large an influence on trustees, especially where they don't feel they have the competence,' said Jeanne Swarts of Bathabile Holdings. 'There should be a balance of executive and non-executive trustees.'

Mahlala pointed out that the principal officer is often very powerful, a top person from finance or the industry. 'Thus he may lead the process and exert undue influence on the trustees.' Yatt said that the role of the principal officer is and should be to act as servant of the board and of the members.

Nematandani noted that most boards only meet once a month or even less frequently, which can be a hindrance in terms of making appropriate decisions. 'The principal officer should never move ahead without ensuring that board members are fully informed.'

The question of how the activities of the principal officer are monitored and supervised was raised. 'Support mechanisms should be available to empower trustees to monitor the principal officer,' said Mahlala.

Conclusion

In summary, the panellists agreed that:

- Member participation should be improved.
- Attention should be paid to how trustees are selected to ensure adequate skills.
- Trustees should be empowered with mandatory training.
- Checks and balances should be built in at every stage of the system to ensure that no role player or party becomes too powerful, acts without adequate supervision, or is able to manipulate decisions.
- Principal officers need to understand their role as servants of the board and members.
- Boards of trustees need a proper 'corporate-style' structure.

Finally, all panellists agreed that there was a need for teamwork and partnership throughout the industry. Only by working together will it be possible to create a more workable, honest and effective system.

MAKE EVERY MOTHER AND CHILD COUNT

The wider use of key interventions and a 'continuum of care' approach for mothers and children that begins before pregnancy and extends through childbirth and into childhood could lead to a sharp reduction in the number of maternal and child deaths, according to the World Health Organization's *World Health Report 2005 - Make Every Mother and Child Count.*

Each year some 3.3 million babies are stillborn, more than 4 million die within 28 days of birth, and a further 6.6 million young children die before their fifth birthday. Maternal deaths also continue, with the annual total now standing at 529 000 deaths during pregnancy (some 68 000 a consequence of unsafe abortion), childbirth, or after the baby has been born.

With a focus on the health of mothers and children the report identifies exclusion as a key feature of inequity as well as a key constraint to progress, with universal access to care for all women and children still far from realisation in many countries. It also calls for a repositioning of 'maternal and child health' as 'maternal, newborn and child health'.

Africa fares worst

The report says that the mortality rates of children under 5 years of age provide a good indicator of the progress made. During the latter part of the 20th century the under-5 mortality rates worldwide fell from 146 per 1 000 in 1970 to 79 per 1 000 in 2003. Since 1990, this rate has dropped by about 15%, corresponding to more than 2 million lives saved in 2003 alone. However, there was also a slowing in the downward trend, and between 1970 and 1990 the under-5 mortality rate dropped by 20% every decade, while between 1990 and 2000 it dropped by only 12%.

Moreover there are significant regional differences, with the slowing down starting in the 1980s in the African and western Pacific regions and in the 1990s in the eastern Mediterranean region. The African region started out at the highest levels, saw the smallest reductions (around 5% per decade between 1980 and 2000) and the most marked slowing down. In contrast, progress continued or accelerated in the Americas and the South-East Asia and European regions.

As a result the under-5 mortality rate is now 7 times higher in Africa than in Europe, compared with 4.3 times higher in 1980 and 5.4 times higher in 1990.

Maternal mortality is also highest in sub-Saharan Africa, where the lifetime risk of maternal death is 1 in 16, compared with 1 in 2 800 in richer countries.

Moving towards universal coverage

The technical knowledge exists to respond to many of the critical health problems and hazards that affect the health and survival of mothers, newborns and children, says the report.

The key issues identified are:

- Improving the outcomes of pregnancy through the provision of good antenatal care, finding appropriate ways of preventing and dealing with the consequences of unwanted pregnancies, and improving the way society looks after pregnant women.
- Attending to the complications of childbirth through the provision of effective professional maternal and neonatal care during and after labour and delivery.
- Improving the health of newborns through programmes to tackle vaccine-preventable diseases, malnutrition, diarrhoea and respiratory infections – these accounting for the majority of under-5 mortality.

Considering the 75 countries that account for almost 90% of all births worldwide and approximately 95% of maternal and neonatal deaths, the following scenarios have been calculated (costs additional to current expenditure):

First, for a move towards universal access to both first-level and back-up maternal and newborn care, and growing of the present 43% coverage (with limited care) to around 73% (with a full package of care) in 2015 and full coverage in 2030, the cost up to 2015 is estimated at US$39 billion (US$1 billion in 2006, increasing, as coverage expands, to US$6.1 billion in 2015). This corresponds to growth in current median public health expenditure in these countries of 3% initially, rising to 14%.

Of these costs, the majority (46% in 2006, rising to 85% in 2015) are for expanded service delivery, in particular drugs, commodities and supplies and remuneration of the extra workforce, while programme development and support and investment in health systems account for 4% and 22% respectively over the period.

Second, to reach all children with a package of essential child health interventions necessary to comply with the Millennium Development Goals, i.e. 95% of children covered by 2015, – US$52.4 billion (US$2.2 billion in 2006, increasing to US$7.8 billion in 2015).

Of these costs 13% are for programme development and support and 87% for service delivery, including salaries for staff, community health worker programmes, and drugs, laboratory tests and other supplies.

Low-income countries in the group, where the situation is currently most difficult, include Angola, Chad, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Mali, Niger, Nigeria and Somalia.

The most pressing task in scaling up maternal, newborn and child health services is putting in place the health workforce needed, the report says.

Source: **www.who.int**

Jonathan Spencer-Jones

PRACTICE MANAGEMENT

HOW TO MANAGE PROFITS: RATIO ANALYSIS

The last two columns in this series on the management of profits have reviewed the calculation of profits, how to improve profitability by managing 'margins up' and 'overheads down', and the determination of the break-even point when your practice is neither making a profit nor a loss.

Once past the break-even point you should establish how profitable is your practice is. A measure of profitability is given by the 'current ratio', which is defined as:

$$\text{Current ratio} = \frac{\text{Current assets}}{\text{Current liabilities}}$$

As a rule of thumb this ratio should be 2:1 for a business to be profitable.