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.

The purpose of determining this and other financial ratios is to reduce the amount of data to a workable format and to make it more meaningful to the manager. There are hundreds of ratios that could be calculated and the manager must learn which combination of ratios is most appropriate in a specific situation and then calculate these on a regular basis to detect trends in the practice. Analysis of these ratios should lead managers to ask the right questions and sometimes they provide clues as to possible areas of strength or weakness.

Profitability ratios can be valuable tools for a business to measure the quality of its profits. The type of profitability ratios used may vary, depending on the type or speciality of the medical practice, the cost of the facilities needed, and/or the individual style of the practitioner. The ratios for different practices may also differ; for example, new practices may not be comparable with established practices.

Doctors who mainly sell consulting services, like physicians and neurologists, are selling their knowledge and skills to earn a fee, whereas diagnostic disciplines, such as pathologists, utilise expensive equipment together with their skills to provide a service to a patient. The overhead structure for the consulting disciplines differs substantially from those of the diagnostic disciplines.

As a general rule of thumb, the overhead cost for medical practices should not be more than 60% of gross profits for solo practices, and not more than 70% of gross profits for multi-practitioner practices or diagnostic practices.

When tracking your business' performance with ratio-trend analyses, it is always useful to keep a record of historical ratios or trends. Every business has a cyclical trend, which will influence expected sales for a specific period. For example an increase in sales in a certain month, say September, might be as a result of allergies and not as a result of a successful marketing campaign, or vice versa. Or the practice may be very quiet during school holidays in December and April, but very busy in the winter months from May to August, with average fees in other months. It is essential, when trying to understand the year-to-date performance of a business, to compare the performance with corresponding periods in previous years or periods, so that new trends can be picked up and acted upon. Without such comparable information, it is not possible to assess whether you are doing better or worse than previous years, and what the reasons are behind the fluctuations.

A manager should understand how to dismantle financial statements in such a way that when he/ she matches one piece with another, they are in a position to:

- compare the performance of the practice this period with last
- compare the performance of the practice with that of competitors
- detect weaknesses to which managerial attention should be directed.

Useful ratios to calculate and compare with previous periods are:

- % growth in sales from year to year
- % gross profits compared with previous years
- break-even amount compared with previous years
- overhead cost as % of gross profit
- overhead cost per patient seen
- gross profit per patient seen.

Another technique is to produce a '100% statement' for the practice, in which sales are set at 100% and each other item is calculated as a percentage of sales (see Table I).

In this example it can be seen that the gross profit increased for the year although marketing expenses increased as a percentage of sales. This is as a result of the lower cost of sales that the practice is achieving. Net profits are down, and there is an increase in general expenses. The practice manager can now explore the reasons behind these trends and gain more insight into the structure of the practice.

Excerpted with permission from the Financial Management section of the Distance Learning Practice Management Programme of the Foundation for Professional Development of SAMA. For information on the FPD courses, contact Annaline Maasdorp, tel (021) 481-2034; ***annalinem@samedical.org***

Table I. A '100% statement' for a practice

	Year ended Dec 2000		Year ended Dec 2001	
	R	%	R	%
Sales	20 000	100.0	25 000	100.0
Cost of sales	16 480	82.4	20 375	81.5
Gross profit	3 520	17.6	4 625	18.5
Marketing expenses	610	3.0	875	3.5
General expenses	315	1.5	500	2.0
Profit before tax	2 595	13.1	3 250	13.0
Taxes	1 295	6.5	1 625	6.5
Net profit after tax	1 300	6.6	1 625	6.5