NEWS

SUSTAINABLE HEALTH SYSTEMS IN PROSPECT

Current health systems are not expected to survive unchanged in the coming years, and the expected trend is a move from being largely public and opaque currently to private and transparent in the future, according to a survey conducted by the World Business Council for Sustainable Development among its members.

The majority of the participants felt that there would be a growth in the role of 'well- informed citizens' who would exert increasing influence on their own health, while only a minority speculated about renewed vigour of the public model of health care.

Some also described a future 'peer-to-peer' world in which the relationship between all actors of a health system, including the individual patient, is more equal – as apparent in the increasing power and sophistication of organised patient groups, such as diabetics, breast cancer patients, etc., that can have a significant impact on research plans, product testing and pricing of health care products and services.

While many cited economic arguments for changing health systems, the main reasons that were mentioned were an inability to communicate real value – particularly by those in the pharmaceutical sector – and the lack of or limited access to health systems, not only among the poor but increasingly the middle class.

Participants also felt that there is an upper limit to what a society will spend on health, and the larger this gets (as a percentage of GDP) the more it crowds out other social responsibilities like education and security. Efficiency gains, the move towards two-tiered systems, i.e. basic social coverage and private extras, and more third party buyer competition were seen as a solution, with power shifting to the consumer as a consequence.

While some participants expected major changes to have occurred in the next 5 years, none believed that current health systems would survive unchanged 15 years from now.

The survey was based on meetings with members and their guests and interviews with almost 50 individuals from the following companies: Allianz, American Enterprise Institute, Aventis, Center for Disease Control, Dow Chemical Company, DuPont, Hoffmann LaRoche, Novartis, Pfizer, PricewaterhouseCooper, Procter & Gamble, Rohm & Haas, Syngenta, US Food and Drug Administration, US National Coalition on Healthcare and World Health Organization.

Source: **www.wbcsd.org**

MOBILITY AND AIDS

It is common knowledge that some two-thirds of people living with AIDS are in sub-Saharan Africa and that the countries worst affected are in southern Africa. A number of different factors have been advanced in explanation, including poverty and economic marginalisation, differing strains of HIV, high rates of sexually transmitted and other opportunistic infections, patterns of sexual contact, the absence of male circumcision, and the role of groups such as commercial sex workers. However, while population mobility in the region is common and has been well studied – involving groups such as mine workers, commercial farm workers, transport workers and military personnel – little work has been done on its interaction with AIDS. To fill this gap, a workshop was held recently in Cape Town to brainstorm research focused on the linkages between AIDS, population mobility and migration in the region.

According to the report of the meeting, which was organised by the International Organisation for Migration (IOM) Regional Office for Southern Africa and the Southern African Migration Project (SAMP), the key areas for research that were identified include:

- impact of migration on rural migrant communities and sexual networking
- role of culture
- evaluation of HIV interventions in the context of migration
- different levels of causation of HIV transmission
- role of population mobility in HIV epidemiology
- health worker migration
- migration induced by HIV and AIDS.

In addition, the need for interdisciplinary research on the link between migration and HIV/AIDS was stressed, as was the need to look at surrounding communities. Research-related ethical and sensitive issues were also highlighted. Participants also indicated the need to ensure that research findings are communicated to policy makers in the region who, according to the report, have not sufficiently understood the policy implications of the connections between HIV and population mobility.

Source: **www.iom.org.za**

DOUBLING THE HEALTH WORKFORCE IN SUB-SAHARAN AFRICA

An initial investment of approximately $2 billion in 2006, rising to an estimated $7.7 billion annually by 2010, is needed from African governments and the donor community to double sub-Saharan Africa's health workforce as well as increase its

effectiveness by 2010, according to a new study from the US-based Physicians for Human Rights (PHR).

The approximate breakdown of funding required in 2006 is:

- 35% for health worker compensation, including stipends for community health workers and raising health workers out of poverty wages
- 10% for incentives to health workers to serve in rural areas
- 25% for health worker pre-service education and continuous learning
- 30% for human resource management and planning; health workplace safety; training, supervision and support for community health workers and caregivers; human resources support for the not-for-profit NGO and faith-based sectors; global and regional support and learning.

By 2010, the breakdown of the funding requirements in these categories will be approximately 45%, 15%, 15% and 25%, respectively. (Note: the estimated needs for health worker compensation as well as incentives to serve in rural areas, which are based on WHO figures on public health expenditure in sub-Saharan Africa, exclude South Africa because of its large health budget compared with the rest of the sub-continent.)

According to the study, which was prepared ahead of the G8 Summit in July, these are the categories of investments in the workforce required to educate, recruit and retain the numbers of health workers necessary to double the health workforce and progress towards minimum coverage densities, to enhance health worker coverage in rural and other under-served areas, and to increase the effectiveness of the workforce by improving health worker motivation and making the best use of health workers' skills.

However, actual funding allocations will vary by country. Due to the time required to graduate more health professionals, each country will have to determine the skills mix that will best deliver equitable and quality health care to its population. In many cases, the mix that will most effectively enable the rapid expansion of health service coverage will involve a restructuring of the workforce by significantly expanding the role of less intensely trained health workers, such as community and village health workers. With support and supervision from professionals as well as community-level accreditation, community health workers, along with people living with HIV/AIDS and home and community caregivers – who are already providing services in an unpaid, untrained, and unsupported manner – can be rapidly mobilised to help quickly scale up access to health services quickly.

The study comments that for this initiative to be successful and result in significant improvements in the health of people in Africa, it must be complemented and balanced by major investments in fighting HIV/AIDS and by other aspects of strengthening health systems, such as service delivery, information management, and other health system inputs such as essential medicines, supplies and equipment.

An earlier study from the Joint Learning Initiative on Human Resources for Health and Development determined that Africa has slightly less than 1 health worker/1 000 population, whereas a minimum health worker density of 2.5/1 000 population is required to make significant progress on global health goals. Thus doubling the health workforce by 2010 would make significant progress towards achieving this goal, the study states, adding that the contribution from the US, commensurate with its percentage of the world economy, should be approximately one-third of the required funding ($0.65 billion in 2006, rising to $2.6 billion in 2010).

The Commission for Africa report, which was prepared to focus international attention on Africa and as one of the main inputs to the G8 Summit, called for a tripling of Africa's health care workforce with the training of an additional 1 million workers over the next decade.

The PHR study was undertaken by a group including Lincoln C Chen, director of the Harvard University Global Equity Initiative and co-chair for coordination of the Joint Learning Initiative, and Eric A Friedman, policy analyst for PHR. Input in the costing estimate included salaries, benefits and incentives (including salaries and benefits for new health workers, improved salary packages and economic incentives to encourage health professionals to work in rural and other underserved areas); expanded health worker pre-service training capacity and development of continuous learning and professional development opportunities; human resource management and planning; training and support for community and home caregivers; improvement in health workplace safety (including universal precautions and other forms of infection prevention and control, post-exposure prophylaxis, psychosocial support, and HIV prevention programmes); and regional and global support and learning for health workforce strengthening.

Source: **www.phrusa.org**

TAXED TO DEATH

Aid to developing countries has increased in recent years and the price of many drugs has fallen, but access to medicines and devices has not increased greatly. The main reasons are the obstacles imposed by recipient countries themselves, in the form of taxes and other barriers.

This is the view advanced by Roger Bate of the American Enterprise Institute, Richard Tren of Africa Fighting Malaria, and Jasson Urbach of the Free Market Foundation, in a recent AEI/Brookings Institute Joint Center for Regulatory Studies paper, 'Taxed to death'.

While there have been numerous initiatives aimed at improving access to medicines, the authors argue that there has been little emphasis on state-imposed barriers, such as import tariffs, duties and taxes that can increase the price of medicines significantly, and on non-tariff barriers such as lengthy registration periods for medicines and onerous customs clearance requirements.

They say that while import tariffs vary widely from country to country, many African countries maintain very low or negligible import tariffs on completed pharmaceuticals and on intermediate pharmaceutical products (i.e. those compounds used in the manufacture of pharmaceutical products). However, there are notable exceptions, including the Democratic Republic of Congo (DRC), Ghana, Kenya, Tanzania, Uganda and Zimbabwe. For example, in the DRC import tariffs on completed pharmaceuticals vary from 10% on most products, to 15% on any medicines containing penicillin, to a high of 18.3% on a range of products, such as antidepressants, anaesthetics, cough and cold preparations and diuretics. In Zimbabwe there is a 5% tariff on most medicines, except for vaccines, which have a zero tariff, but for adhesive dressings and bandages the tariff is 20%, perhaps in an effort to protect a local industry from international competition.

In addition there are taxes such as VAT, as well as other charges and duties. For example, Kenya imposes an 8% port charge, a 1% clearance and freight charge and a 2.75% charge for pre-shipment inspection. Among African countries taken together, these charges and duties ensure that the combined state-imposed increase in prices to patients of pharmaceutical products range from as low as 11% in Botswana and Namibia to as high as 38% in Kenya and Morocco, the researchers say.

In the case of South Africa the researchers say that notwithstanding the 'draconian drug pricing regulations' passed by the government in an effort to reduce the price of medicines to private consumers, 14% VAT is maintained on all medicines.

Considering the case of HIV/AIDS they comment that as a result of the largely inadequate programme to provide antiretroviral therapy through the state health care system many people living with HIV/AIDS seek treatment through the private sector, where a month's supply of antiretroviral triple therapy consisting of Combivir and nevirapine is likely to cost approximately R586 ($101) for the drugs alone. Of this amount, R72 ($14) is paid directly to the government in the form of VAT. If the government were to waive VAT, however, patients would be able to afford more of the fresh fruit, vegetables and meat that they should consume in order to remain healthy and be able to maintain their antiretroviral therapy (Table I).

Table I. A basket of goods that a patient could afford if VAT was not imposed on antiretroviral drugs

Item	Unit cost	Quantity	Total (Rand)
Brown bread	R3.59/loaf	2 loaves	R7.18
Eggs	R1.05/egg	6 eggs	R6.30
Low fat milk	R5.69/litre	1 litre	R5.69
Maize meal	R2.59/kg	1 kg	R2.59
Bananas	R4.99/kg	1 kg	R4.99
Beetroot	R5.32/kg	0.5 kg	R2.66
Tomatoes	R9.99/kg	0.5 kg	R4.99
Broccoli	R5.99/kg	0.5 kg	R2.99
Lean minced beef	R27.95/kg	0.5 kg	R13.98
Whole chicken	R18.99/kg	1.1 kg	R20.89
Total			R72.26

'Among the billions of rand raised by the South African government, the R72 raised via VAT on each person's monthly antiretroviral therapy makes little difference to the life of the government, but that money can make an enormous difference to the lives of ordinary South Africans living with HIV/AIDS.'

Overall the researchers estimate that a 1% reduction in import tariffs would increase access to essential medicines by just under 1%. However this is extremely tentative as confounders such as literacy and the state of health care facilities have not been ruled out as plausible alternative explanations for lack of access. Further research is planned to address these factors and perhaps lead to stronger conclusions.

The researchers also comment on the drug regulation process and in the case of South Africa they note that on average drugs that have been registered for use in the US, EU and Japan can wait for 39 months for approval in the system.

'The inefficiency and obstructionism of drug regulators imposes enormous, though largely unquantifiable, costs on manufacturers and patients,' they say. In addition to the reduction and removal of taxes and tariffs on medicines, 'reform of the regulatory regime and customs procedures is an essential step for developing countries to take in order to reduce the cost of medicines to the world's poorest people.'

Jonathan Spencer Jones

PRACTICE MANAGEMENT

COORDINATION OF FINANCIAL RESOURCES

Having reviewed the areas of profitability, cash flow and asset and debt management, we now look at the coordination of these three areas. In order to run a medical practice efficiently, it is imperative that all these aspects are attended to and successfully managed.

The two key elements of effective coordination of financial resources are:

- regular and accurate financial information regarding the current performance of the business