



NEWS

HEALTH EXPENDITURE – 'INVESTMENT' RATHER THAN 'COST'

There is a two-way relationship between economic growth and health, with life expectancy and adult survival rates exercising a positive impact on human capital formation and hence economic growth, and in turn sustained growth rates allowing for better health conditions. Accordingly governments should think of health expenditures as an investment and not as a cost, and therefore should adopt a long-term perspective, say Rifat Atun, director, and Ipek Gurol-Urganci, research fellow, of the Centre for Health Management of the Tanaka Business School of Imperial College London, in a new Chatham House paper (IEP WP 05/01).

Considering the rationale for investing in health – including enhanced labour productivity and higher lifetime earnings – and the consequences of not investing in health – including increased impact and costs of diseases and decreased worker productivity – the authors say that despite the growing body of evidence on the benefits of health investment, in most developing countries it remains low and well below the European Union average of 9 - 10% of GDP (2003 figures, ranging from around 11% of GDP in Switzerland and Germany to around 5% in the Slovak Republic and Latvia).

A further issue in Europe is the ageing population and the associated epidemiological transition, with an increase in chronic illnesses and consequent changes in health needs and demand patterns, which require different care delivery patterns. Ageing itself does not increase health expenditure, but an ageing population with poorly managed chronic illness does. Since 1995 changing demographics are estimated to have resulted in an incremental health care spend of US\$1 trillion in the USA, US\$170 billion in Germany and US\$100 billion in both Japan and China.

Demographic and epidemiological changes, better-informed citizens and the increased availability of innovative medical technologies will all lead to increased demand for health care services and growing health expenditures. At the same time government intervention is needed to create an enabling environment where appropriate investment in health is ensured and people's health needs are met.

The reorganisation of health systems to enhance allocative and technical efficiency should be a priority for governments, and a shift from hospital-intensive health systems to the primary care domain would yield benefits to all the key stakeholders. Governments also need to achieve better symmetry between the health system objectives of equity, efficiency, effectiveness and user choice by learning to listen to their citizens.

Source: www.chathamhouse.org.uk

SUPPORT FOR TB

Pharmaceutical company sanofi-aventis, through its social responsibility project TBFREE, has pledged to support the South African national Department of Health in the management and control of TB in South Africa. Signed on 19 August at the Sizwe TBFREE Centre by Dr Robert Sebbag, sanofi-aventis vice-president – solidarity mission on access to medicine – and the Minister of Health, Dr Manto Tshabalala-Msimang, this is the first such agreement in South Africa and formalises the public-private partnership that already exists between sanofi-aventis, the Nelson Mandela Foundation and the Department of Health.

The Sizwe TBFREE Centre in Edenvale is one of four centres already established by TBFREE for training community health workers in DOTS (directly observed therapy support). Sebbag stressed that in South Africa the main issues are education, information and compliance – the medications are free, but the task is to get them to people in need and to ensure that they take them. In her keynote address, the minister said that the signing is in line with her strong belief that we need to work together to solve health care problems, not just in South Africa but in Africa as a whole. She hoped that a comprehensive approach to care would include promotion of good nutrition and a healthy lifestyle, 'not just tablets and training'.



Holding up the public-private partnership agreement for the management of TB control in South Africa, are Dr Robert Sebbag of sanofi-aventis and the Honourable Minister of Health, Dr Manto Tshabalala-Msimang.

Since training commenced in 2004, TBFREE has trained more than 3 500 community health workers, who not only provide support to TB patients but ensure that health education and information reaches both patients and communities.



This agreement was formalised just 1 week before African ministers of health, meeting at the WHO regional committee for Africa's 55th session in Maputo, Mozambique, declared TB an emergency in the region. Since 1990 the number of new TB cases in Africa has quadrupled, with more than half a million deaths per year resulting, and countries were urged to commit more human and financial resources to strengthen DOTS programmes and scale up collaborative interventions to fight the co-epidemic of TB and HIV – as laid out by the global Stop TB Partnership, which has called for US\$2.2 billion in new funding for TB control in Africa during 2006 - 2007.

In contrast, elsewhere in the world TB trends are either stable or in decline and are on track to reach the MDG target of halving TB prevalence and deaths by 2015.

SOUTH AFRICAN HEALTH CARE IN THE WORLD CONTEXT

Mx Health's Quarterly Health Review took a different form on 30 August 2005, with a single speaker replacing the usual panel discussion. Susan Mynhardt, Business Development Executive at Mx Health, who has done active research into health models from all over the world, took an in-depth look at the South African health care system and its unique problems and challenges. How do we compare with the rest of the world, and how can we learn from mistakes elsewhere?

South Africa undoubtedly has much to learn from other countries, but who can we compare ourselves to? We need an index – as Mynhardt put it, 'so we are comparing apples with apples'. The human development index (HDI) is useful here, measuring not just income but how it is spent, and taking into account various indicators of quality of life such as democratic issues, freedom of speech, education and literacy, gender equality, and access to basic needs such as water and sanitation. At the moment South Africa (at no. 119) has a medium HDI. So why are we comparing ourselves with countries like the UK, Germany and the USA, all of which have a high HDI? And it is interesting to note that our future health care funding provision model appears to be a combination of the systems currently being used in Australia, Belgium, Canada, France, Germany, Ireland, the Netherlands, UK and USA – all of which have a substantially higher HDI than South Africa.

Within the South African market, 5.1% of GDP is expended on health care at private level and 2.6% within the public health care arena. Private health care expenditure in South Africa is therefore effectively 50% higher than that in the public sector – and only 7 million or so of our population of 43 million have access to that private care. But Mynhardt stressed that research shows that both private and public health care sectors need to be healthy, and despite its high cost the quality of our

private health care services remains among the highest in the world. Effectively, there is no model in the world that can right the wrongs of our past while ensuring that we uphold the high standard of care that currently exists in the private sector.

Health care delivery in South Africa is often stymied by the most basic of issues, such as access to clean water, a reasonable stable diet, shelter, and transportation to health care service points. With such problems, is a doctor-centred model the most appropriate? As Mynhardt put it, health care is a social issue first and a funding issue only second – the 'benefit package' itself is a relatively small part of the health care delivery problems we currently face. She illustrated this with the example of the current social grant, which because of dire poverty and need may encourage a teenager to have unprotected sex so she can become pregnant and access the grant. With the ripple effects of possible exposure to HIV/AIDS, increased poverty and a bleaker than ever future, this shows how a laudable idea can have unintended consequences in a world where human beings are faced by

unimaginable material hardships.

Looking at South Africa's undeniable problems – including a seriously overburdened state service, dramatic increases in cost of health care cover for the insured sector of the population, seriously under-



Susan Mynhardt.

remunerated doctors, more and more of whom are being lured to other countries by better pay and better conditions, and ever-increasing utilisation of services at doctor, specialist and hospital level – it comes as some relief to know that health care expenditure is rising globally and we are not alone in our difficulties, or in our quest for a workable, cost-effective health care funding model. Mynhardt gave two examples – in Germany, which currently has one of the highest health care expenditures in the world at around 10.8% of GDP (8.1% in the public sector, 2.7% in the private sector), consumers are plagued by below-standard care, under-servicing and poor outcomes despite increasing costs, and in the UK the NHS has failed to cope with the demand. Dissatisfied patients have long demanded better services, and there are waiting lists of up to 3 years for elective procedures.

But the issues we face here are complex and many-faceted, and Mynhardt emphasised that we are unique and need a unique solution – a South African health care model that will work for us, 'a very special South African work of art'.



THE FULL COST OF HIV/AIDS TREATMENT

Coping with the HIV/AIDS pandemic remains a daunting task for the global health community and the issues extend far beyond the price of AIDS medicines alone, according to a new Hudson Institute White Paper 'The Full Cost of HIV/AIDS Treatment', by Carol C Adelman, Jeremiah Norris and S Jean Weicher.

The White Paper, which updates an earlier study ('Myths and realities on the prices of AIDS drugs' published in 2004), finds that patented drugs are either less expensive or fall within the price range of copy drugs, with the exception of nevirapine, which is provided by the company free of charge for mother-to-child transmission programmes. Therefore, price is not a rate-limiting factor to treatment and in fact its significance is negligible compared with other barriers – high tariffs and taxes, counterfeiting, trade diversion, drug resistance, and absorptive capacity.

The White Paper notes that the first true generic antiretrovirals (ARVs) have only just emerged on the market. In December 2004 Barr Laboratories in the USA became the first company to win approval for a generic ARV from the Food and Drug Administration (FDA) under its fast-track process, with approval for production of didanosine. This was followed in January 2005 by Aspen Pharmacare, with approval for a co-packaged ARV double-dose regimen containing lamivudine+zidovudine, plus a separate tablet of nevirapine.

However, at the same time a number of WHO pre-qualified drugs have been de-listed, withdrawn by the manufacturer owing to discrepancies in the bioequivalency tests or labelled as 'undesirable' by the South African Medicines Control Council, bringing the total number in these categories to 18 as of November 2004.

TARIFFS AND TAXES

The issue of import duties, customs tariffs and value-added taxes on drugs was reviewed in the last *SAMJ* (September 2005, p. 642). Full data are difficult to obtain, but one study found the average of these taxes globally was 18%, ranging from 0.01% in Malaysia up to 60% in India.

However, these are not the only hidden costs that increase the price of a drug, and others include markups by local wholesalers, distributors and retailers, transportation, storage, clearance and freight stock losses, and procurement practices. Combined with the tariffs and taxes these additional costs are estimated to be sometimes more than double the manufacturer's price.

For South Africa the total hidden costs mark-up is estimated at just over 74%.

COUNTERFEITING AND TRADE DIVERSION

The issue of counterfeit drugs is most pronounced in developing countries, with some 70% found there. In 2003, approximately a quarter of medicines consumed in these countries were thought to be counterfeit, the vast majority for treating malaria, TB and AIDS. However, percentages vary among countries and in Nigeria, for example, counterfeit drugs are thought to account for up to 50% of drugs sold there.

The absence of laws against counterfeits and proper law enforcement accounts for the problem in many countries. For this reason, re-exported counterfeit drugs are a risk to both developing and developed nations. For example, it has been reported that 25% of GlaxoSmithKline's discounted AIDS drugs bound for Africa did not arrive at their intended destinations between June 2001 and July 2002.

The increased use of counterfeit and substandard drugs can have at least two serious consequences: a donor or country spending scarce foreign exchange to acquire worthless products; and the inducing of drug resistance earlier than if legitimate drugs were used – this latter a huge future unfunded liability for countries.

DRUG RESISTANCE

Most data on drug resistance in developing countries are in the preliminary stages of being collected but clinical experiences in the USA and EU on ARV treatment over the past two decades strongly suggest that it is a persistent problem.

Using WHO's plan to treat 3 million patients by the year 2005 as a model, and a figure of 10% per annum for the development of primary HIV-1 drug resistance, in 2010 there will be an estimated 3.3 million drug-resistant patients, out of a total of 8 million who are undergoing treatment. Based on the cost of the ARV cocktail of the single-dose drug efavirenz and the FDC lamivudine and zidovudine, which is often prescribed in the UN Accelerated Access Initiative (UN AAI), the estimated per person per year cost for second-line treatment is \$2 653 and the total, including medical infrastructure costs, to treat just the drug-resistant patients over the next 5 years is \$44 billion.

DISBURSEMENTS AND ABSORPTIVE CAPACITY

The Global Fund for HIV/AIDS, TB and Malaria had \$1 billion in commitments by 2004 but its disbursements fell from \$400 million in 2002 to less than \$100 million by 2004. Similarly the World Bank had commitments for these diseases in 2003 of approximately \$450 million but disbursed less than \$200 million, while in 2004 \$210 million was disbursed, against \$400 million in commitments.



Reasons why disbursements lag behind the commitment of funds include lack of management staff at field level, availability of health personnel, storage and distribution capacities, and sufficient diagnostic services. Moreover there are concerns about the absorptive capacities of aid flows to countries, due to the associated institutional constraints.

The donor community and recipient countries have never before faced the triple dilemma of high dollar commitments and constrained disbursement levels against finite absorptive capacity rates. Effectively managing this triple threat may be as daunting as is the global fight against AIDS, TB and malaria.

Source: www.hudson.org

PRACTICE MANAGEMENT

INFORMATION TECHNOLOGY IN PRACTICE: COMMUNICATIONS

There is no doubt that information technology (IT) and information is very much part of our lives today. Several different areas can be supported by technology and provide a health practitioner with a comprehensive infrastructure for a practice (Fig. 1). Over the next 3 months we will review all of these areas (except infrastructure -- due to the rapid changes at this level, the basic approach should be to define the IT applications that the practice requires and to purchase the most current infrastructure that can be afforded).

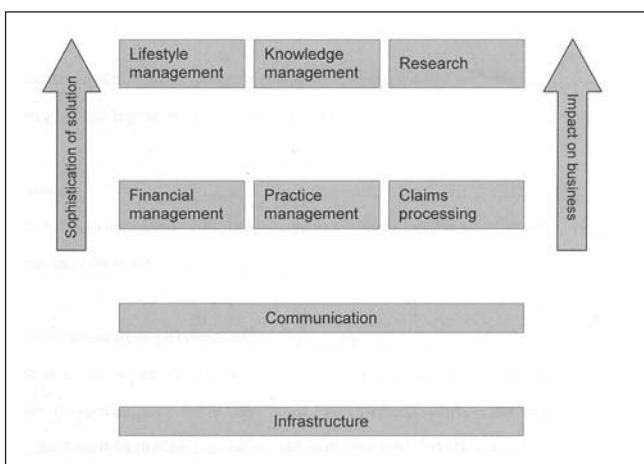


Fig. 1. IT in health care practice.

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Communications

Electronic communication, both internal and external, is one of the basic necessities of a modern business and there are several mechanisms that can both simplify and enhance management of a practice. These are:

- e-mail and e-fax

- calendaring and scheduling (C&S)
- short message service (SMS)
- document management.

Because the use of the Internet features in most of these communication mechanisms, accessing and utilising the Internet will be described first.

The Internet

The Internet is an international network of computers connected together across almost all countries of the world. The main components of the Internet are:

- World wide web (www), which is a vast resource of more than eighty million pages of information in graphic, audio and/or video format. Pages are representative of anything from individuals through clubs, associations and small companies to the largest corporations. Through building in links to other software systems, e-commerce (buying and selling through the Internet) has also become possible. The language of the Internet is HTML (HyperText Markup Language) and the network system by which data are transmitted is HTTP (HyperText Transmission Protocol).
- Newsgroups and message boards, which allow a degree of interaction between visitors to a site. There are many thousands of newsgroups available, which are grouped according to content and within them are many messages. Some groups are moderated, in that somebody takes it upon himself or herself to edit or censor the content.
- Chatrooms, which allow live interaction between Internet users. When one person enters a comment and presses the enter key, the comment is simultaneously displayed on the screens of all the participants in the chat session, regardless of where they are in the world.

E-mail and e-fax

Basic e-mail consists of sending and receiving text-based messages across an electronic network. E-mail can be sent within a practice across a local area network (LAN), but will more often take place across the Internet. E-mail can also be used to distribute electronic files of various sorts, including word processor documents, spreadsheets and digital photographs.

E-fax consists of using e-mail infrastructure to send and receive faxes electronically. One of the biggest advantages of e-fax is that faxes don't have to be printed out before being sent, and incoming faxes are available in electronic format for storage online, rather than just on paper.

Some of the key uses of e-mail and e-fax in the health care industry are:

- communication with partners or associated professionals and organisations