

He said the lack of insurance coverage for health care students working in State facilities was a 'major concern'. For the first five years, students were not covered by provincial or national governments for needlestick injuries because they were not defined as 'employed'.

A mechanism was needed to cover this because if a student seroconverted,

they would be left financially helpless.

'This is where the government versus non-government argument comes in - they're not State employees, but they're serving in State facilities!' he said.

Some universities, like the University of Pretoria and Wits had taken the initiative and started partnering with their alumni to start funds to cover student counselling and treatment.

Orr said that the Wits Health Science Faculty provided cover for medical students against occupational exposure 'from day one - we don't rely on the province or State'.

A survey conducted at University of Durban/Westville several years ago revealed a prevalence rate of 17% among their student population.

Chris Bateman

MECHANICS OVERHAUL ETHICS POLICY

'Like trying to adjust the wheels of a car while it's in motion,' was how Boyce Mkhize, Registrar of the Health Professions Council of South Africa (HPCSA) described last month's policy workshop on undesirable business practices in the health industry.

If the profit motive without moral guidance was blind, then moral inspiration without financial backing was bankrupt.

Adjustments suggested by key stakeholders to a draft policy vehicle, which had little visible guidance from a patient-based constituency, would be finalised by October, Mkhize said.

Chairpersons or representatives of the various professional boards and associations, SAMA, the national and provincial departments of health, pharmaceutical companies, optometry businesses and private hospital executives were among the estimated 100 delegates.

Interviewed by the *SAMJ* at the Saint George's hotel outside Pretoria during a break in proceedings, Mkhize conceded that there was a lack of 'patient' participation at the workshop.

'The problem is how you get them. We have two community representatives on our council appointed by the ministers (of Gauteng and Limpopo Health Departments)

here, plus Thandi Manganwe, deputy director of Human Resources at the national health department and the optometry board,' he added.

Gauteng Health Department's Sisa Mjikelane, a former Nehawu activist now serving on the HPCSA (one of nine such provincial appointees on the council) said the HPCSA was 'beginning to transform and open up so it can take up interests and ideas from other bodies'.

However community representivity and patient input were 'taking longer' because of the 'complexity' of the constituency and 'us working out how to articulate their views'.

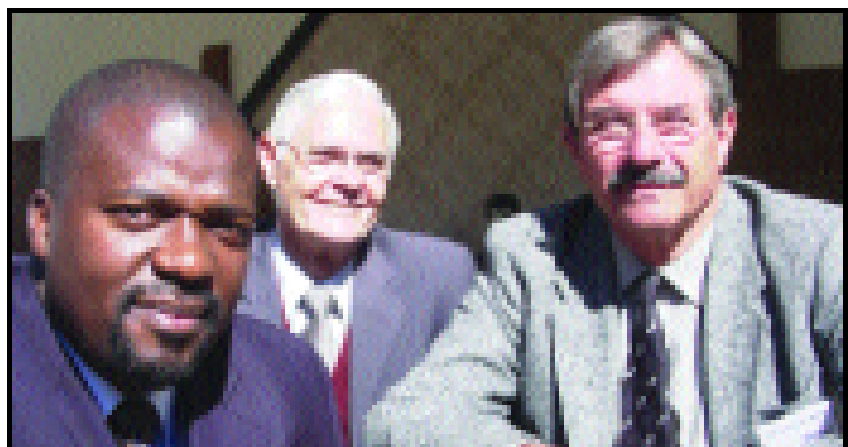
His exact role and function on the council as a community representative was 'somewhat trial and error', but

there was 'an appreciation that, at some stage, it has to get clearly defined and visible'.

Mkhize said 'patient' input had mainly informed policy when HPCSA regulations were originally put out for public comment in the government gazette.

Introducing the workshop, he said his executive committee had put together a task team including the Medical and Dental Professions Board (MPBP) chairman, Professor Len Becker, and former chief investigator into shady health business practices, Professor Jan van der Merwe.

Their job had been to probe the industry and draw up a preliminary draft policy. 'We want to ensure the HPCSA remains true to its mission of



Throwing light on shady business practices - Advocate Boyce Mkhize, Registrar of the HPCSA, Professor Len Becker, chairman of the MDPB and former task team chief, Professor Jan van der Merwe.

Picture: Chris Bateman



protecting the public while restoring professional dignity and confidence - there seems to be a growing concern at the systematic but rapid erosion of ethical mores in the professions'.

Becker and Van der Merwe had identified which health professions were most involved in ethically suspect financial schemes, ownership of high-tech equipment with 'underlying conditions', those employers abusing health professionals and various shady business.

Mkhize told the *SAMJ* that the HPCSA was pursuing a dual strategy.

One was to create a coherent, unambiguous short-to-medium-term policy framework 'which clearly articulates on problems bedeviling the health industry'. The other was dealing with unethical behaviour.

Waving his palm above the ground, Mkhize said his task team had collected files 'this high' while investigating 'nearly all' the major pathology laboratories. There was 'a lot of uncovering of corporate ownership issues,' which had already resulted in one preliminary perverse incentive hearing.

Optometry franchises were also being probed.

The first move against one such franchise led to it taking the HPCSA to court in December last year in a case which the HPCSA was vigorously opposing.

Two MDPB professional conduct enquiries involving R2.3 million in alleged kickbacks by former members of Gauteng's Illes and Partners (radiologists) to five referring doctors were ongoing in spite of litigation.

Mkhize said documentation in other 'sensitive probes' was being finalised with a view to further professional conduct enquiries.

Although he declined to elaborate, the *SAMJ* has reliably learnt that this may involve at least one case of over R7 million worth of kickbacks by a

radiology practice unidentified at the time of going to press.

Mkhize said: 'We've done far more than just what Jan did (Van der Merwe resigned amid some controversy as a specialist investigator last year)'.

The HPCSA was 'now far advanced in terms of dealing with the ills confronting us and we've made significant forward gains'.

In at least four major pathology laboratories contractual arrangements around corporate ownership had been found to be contrary to HPCSA regulations. He expected all of these to go to preliminary hearings 'within the next month or two'.

There seems to be a growing concern at the systematic but rapid erosion of ethical mores in the professions.

One professional conduct hearing into kickbacks by a pathology laboratory was finalised in January this year, with the MDPB committee 'affording them the opportunity to pay a hefty admission of guilt fine'.

He expected the 'enriched' policy document which emerged from the workshop to be revised by a multidisciplinary task team and endorsed by his full council.

Mkhize believes the policy will inform government regulation of private hospitals.

Becker, outlining the existing ethical rules, told workshop participants that they should 'try and fit' the amendments to the rules.

Becker said advertising in the industry was creating a lot of tension, with some players describing the rules as archaic and others incensed by far-fetched and downright dangerous claims made on the Internet.

'We need to ask ourselves - do we want to be judged by the superlatives

we use to create an image of ourselves, or by our performance?' he said.

Touting and canvassing for patients in any form was outlawed.

For a practice, a practitioner could only use his or her name, plus that of a registered practitioner partner. The practice name could be retained in perpetuity while the use of the expression 'hospital', 'clinic' or 'institute' or any other special term was banned.

Corporate entities were not allowed to partner with practitioners and no fees or commissions could be paid for services which were not personally rendered (unless by a registered partner).

Consulting rooms could only be shared with someone who was a registered practitioner while no nameplate could be placed at the entrance of any other business, nor could patients come in via the entrance of such a business.

No practitioner could permit themselves to be exploited in a manner that was detrimental to the public or their professional interest.

Any registered practitioner who had a financial interest in a hospital should place a conspicuous notice to this effect in their waiting rooms and verbally inform patients about this interest.

Prof. Van der Merwe told the gathering that if outsourcing administration 'picked up' a major percentage of total income, then the health professional was 'obviously employed' and this was also not acceptable.

He believed that the current heavy corporate involvement with pathology and radiology was 'completely unacceptable' and contrary to the freedom of a health care professional to practise.

Health care models had moved a long way from where patients chose a doctor because of his or her reputation, paid the doctor themselves and strayed from strong professional values of compassion, respect, dignity,



competence, concern for justice, benevolence and truth.

Instead they had metamorphosed through a government and insurer regulatory model, to a market model where there was conflict between the idea of the profession as a calling and as a career with an entrepreneurial emphasis.

Van der Merwe stressed that the American Department of Justice had declared health care fraud the 'crime of the nineties' and said it was making it the highest priority after violent crime. He said that if the profit motive without moral guidance was blind, then moral inspiration without financial backing was bankrupt.

There were currently opportunities to 'come up with all sorts of schemes at the cost of the patient'.

'We're not there any more to provide an appropriate and caring system for the patient. We're there to practise our business and make money,' he added pointedly.

Chris Bateman

SHISANA HITS BACK AT HER CRITICS



Professor Olive Shisana.

The Director of the Human Sciences Research Council (HSRC), Professor Olive Shisana, has hit back at detractors of her national household HIV prevalence survey, accusing them of having failed to try and understand the study's methodology and findings.

Her critics, KwaZulu-Natal's chief virologist, Professor Alan Smith and Professor Rob Dorrington, Director of the Centre for Actuarial Research at UCT, cautioned against 'jumping to policy conclusions,' based on what they labelled 'a potentially biased' study.

The study, the first and only major attempt at community-based HIV epidemiology in the country, estimates the overall HIV prevalence among people over two years old to be 11.4% –

about 1% less than Dorrington's extrapolations of the more widely quoted antenatal prevalence figures.

However, what raised eyebrows and created headlines in the non-scientific community were dramatic differences between her provincial prevalence figures and the provincial antenatal prevalence figures.

These put the Free State and Gauteng (both 15%) ahead of KwaZulu-Natal (12%) and Mpumalanga (14%) as the provinces with the highest HIV/AIDS prevalence.

In contrast, the antenatal prevalence figures (2001 antenatal clinic survey) had KZN topping the prevalence charts at 34%, Mpumalanga and Gauteng next at 30% and the Free State at 29%.

There was currently no international standard for response rates for large-scale population-based HIV surveys.

Shisana said people failed to appreciate how different the two study methodologies were.

The antenatal numbers were drawn from a highly selective cohort of sexually active, young, black pregnant women aged between 15 and 49 whereas hers were drawn from a broader cohort of men, women and

children of all races aged between two and 90.

'HIV/AIDS is a complex epidemic and no single piece of research can be finite in scope, nor definitive in its findings,' she said.

She emphasised that prevalence percentages of antenatal data did not translate directly to percentages in the adult population and that various formulae were applied to calculate rates for non-pregnant women, men, children and others outside the antenatal sample.

The household survey finding of 24% among pregnant women compared with 24.8% for the 2001 antenatal survey and estimated total infections of 4.5 million (household) versus 4.7 million (antenatal) suggested consistency between the two studies.

While Dorrington described the Shisana study as 'potentially valuable and helping us to get to grips with the epidemic,' he said it failed to fully portray shortcomings in its executive summary and its representations to the media.

Smith was more critical, pointing to the low response rate, the wide confidence intervals resulting from small samples and the lack of age standardisation.

He demanded Shisana's raw data, saying he suspected a predominance of 'people over 50 or 60', which would dilute the results. Shisana and her team