SA'S DOCTORS TAKE TO THE STREETS

South African politicians will never again be able to depend on the innate conservatism and traditional low profile of doctors to enable them to dictate what is best for the country's patients.

Last month a racially united and exasperated SAMA put an end to that.

Nearly 2 000 doctors from all over the country flooded the streets of Cape Town in a public spectacle that evoked images of the apartheid heyday of the United Democratic Front.

After an undignified public spat with SAMA over its even holding the march, the government fell back, satisfied with last-minute concessions to march past parliament and only protest after its 10-year democracy anniversary celebrations were over.

Doctors avoided personal attacks on the Minister of Health, Manto Tshabalala-Msimang, acceding to SAMA chairman Kgosi Letlape's pleas to lower banners critical of her and mostly stuck to issue-based chants and placards.

In spite of anger and chants of 'parliament, parliament', the mass of doctors, supported by scores of patients, dispersed peacefully after seeing acting director general of health, Dr Kamy Chetty accept a memorandum from Letlape at Cape Town's Grand Parade.

Tshabalala-Msimang's glaring absence was taken as further evidence of her reticence to engage, prompting some protestors to shout, 'where's the real health minister?'

Yet the point was powerfully made — doctors cared about their patients and would no longer stand for being ignored by politicians.

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While there is some consensus between SAMA and the Department of Health that most of the legislation is well meant, disagreement about its net effect on doctors and patients remains vociferous.

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Some ANC party stalwarts even accused SAMA of wanting to 'deliberately embarrass' President Thabo Mbeki, discredit his government and undermine transformation.

In stark contrast, SAMA charged that the national health ministry had for nearly 2 years 'deliberately ignored' their ongoing attempts to engage and flag critical health issues, thus making dialogue and input around health care delivery issues impossible.

SAMA charged that public health care was dismal, conditions in prisons and refugee camps shameful and that tertiary health care was collapsing.

Shabby working conditions and low pay and dismal career-pathing for public sector doctors were eroding health care delivery, already under siege from the HIV/AIDS pandemic.

Private practitioners were confronted with seismic new laws that would destroy their futures and reduce health care to a centralised, inefficient state monolith.

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While recent government attempts to mitigate the situation by pumping R500 million into scarce skills retention and rural incentives were welcomed by SAMA, doctors questioned how effective this would be without vital equipment and infrastructure.

Letlape and his colleagues emphasised the stark pay disparities between lower qualified and inexperienced senior public administrators and hands-on doctors, some with up to 35 years' experience.

SAMA has consistently campaigned for a separate bargaining chamber where doctors' specific complaints and arguments can find purchase and not be diluted or lost along with the concerns of a multitude of other public sector categories.

Tshabalala-Msimang's hard-line negotiating stance remains that doctors are 'just another category' of public sector worker.

SAMA vice-chairperson and former public sector chair, Dr Denise White, cited the 16 notches in each public sector salary group with promotion set at one notch per year as a major reason for the deepening discontent.

She said this meant that a public sector doctor could 'sit' for 16 years earning 'perhaps R500 to R1 000 extra each year'.

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White said lack of essential equipment and medication at all levels was forcing senior doctors to draw up emergency coping guidelines to deal with critical staff shortages and legal threats from patients. Junior doctors in rural areas were running hospitals while contending with shocking living conditions, and some saw up to 150 patients per day at clinics.

Since the government's shift to beef up secondary and primary health care, the capacity for supervising and training registrars was declining at an alarming rate.

There are 10 ministries of health overseeing what has been a loss of nearly 50% of state beds over the past 7 years.

At Groote Schuur Hospital, bed provision has dropped from 1 752 to 850 beds while there are now 10 medical superintendents, most of them nursing managers.

Letlape hands over the SAMA memo to Acting Director General of Health, Dr Kamy Chetty.

At last year's September SAMA conference entitled, 'Strategies for the Survival of Doctors', Letlape announced SAMA's new partnership with trade union giant Cosatu and accused the government of 'abandoning' doctors who were, he said, 'the very backbone' of health care delivery.

According to World Health Organisation figures, South Africa's health system ranks 175th in the world yet sits at number 57 in terms of health expenditure. By comparison Uganda has a health system globally ranked 149th in spite of its health expenditure being ranked a lowly 168th.

The most reliable survey yet on the impact of the HIV/AIDS epidemic on health workers found that 16.3% were HIV-positive and that nearly half were 'exhausted and stressed' from a four-fold increase in AIDS patients over the past 5 years (HSRC, 2002, Dr Olive Shisana). It found that district hospitals were taking the biggest strain at 91.8% of AIDS-related medical bed occupancies. Just over 73.4% of respondents found the heavy workload the most debilitating environmental factor while 40% said they worked more than 'official hours'.

One of the biggest pull factors for doctors leaving the country is illustrated by a WHO study that shows that the United Kingdom spends 173 times more on health staff than South Africa (and has a 10-year staffing plan).

The two main laws threatening doctors are the Medicines Control Amendment Act (forcing the special licensing of dispensing doctors and creating a single exit price for medicine from factories) and the National Health Bill that includes the contentious Certificate of Needs (CON), regulating where doctors may practise in future.

SAMA has petitioned President Thabo Mbeki not to sign the CON into law and was prepared to fight its unconstitutionality if he ignored the detailed objections.

The legislation gives provincial directors general of health absolute power to grant or refuse CON, whose legal tenure was recently increased from 10 years to 20 years (after which doctors have to re-apply). The minister is the final arbiter in disputes.

He said the net effect was that, 'if you haven't applied for a CON — whether your practice exists or you're setting one up — you become an illegal operator'.

Letlape scoffed at Tshabalala-Msimang's 'reassurance' that the law would 'not be applied in a draconian way to existing practices', and that the government would be 'mindful' of investments doctors had made.

He shot back: 'Let's put that in the legislation — we want protection from the moods and whims of the minister of health'.

Proponents of the bill argue that elements such as a grandfather clause are 'too detailed' to be put into the actual law and are therefore best included in the regulations.

Letlape replied: 'All they need do is state that they are applying the CON

Protesting doctors bypass parliament.

prospectively in the bill — but they don't, the law is silent on this, which leaves established practitioners exposed'.

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Dr Chetty accused Letlape of 'creating the impression that doctors will be uprooted from their practices because some will get the certificate and some will not. That's not true'.

Another major bone of contention is the effect of amendments to the Medicine and Related Substances Control Act.

The government proclaims that they will result in major savings to poorer people but has been notably less vocal about their effect on future public drug access.

Letlape says drugs will in fact cost poor people more — and Maureen Kirkman, head of scientific and regulatory affairs at the Pharmaceutical Manufacturers Association, agrees.

The reality in townships and rural areas is that patients have better access to private doctors than to pharmacies.

Kirkman said the impending amendments had already resulted in 'perverse but probably legal' new methods of marketing and selling drugs. Among the methods that stood to negate the good intentions of the law were retainer fees paid to doctors for 'information', payment for 'shelf space' in stores (and pharmacies), and payment of 'listing fees' to get products onto medical aid formularies. She said retailers were also threatening to treat medicines as 'consignment stocks'.

The dispensing law comes into effect on 1 May.

Letlape warned that if laws compromised patient care, 'we'll defy them'.

Chris Bateman

IN BRIEF

Low cardiovascular risk at middle age and QoL in older age

Some authors speculate that increased longevity may lead to large numbers of ill, disabled, older persons with lower quality of life (QoL). To determine the truth or otherwise of this belief, a study recently evaluated the relationship of midlife low-risk status with illness at older age.

A cohort of middle-aged adults who were aged between 36 and 64 years between 1967 and 1973, were followed until 1996. At baseline, they had no major electrocardiographic (ECG) abnormalities or history of diabetes or myocardial infarction (MI). They were stratified into low risk (favourable blood pressure and serum cholesterol concentrations, no smoking, and no minor ECG abnormalities; 0 risk factors (i.e. no high-risk factors but >1 risk factors not at favourable levels); or any 1, any 2, or 3 or more of the following 4 risk factors: high blood pressure, high serum cholesterol concentration, smoking, and minor ECG abnormalities.

QoL on physical, mental and social well-being, and self-reported diseases were assessed after 26 years of follow-up.

The adjusted scores for physical, mental and social function and disease-free outcomes were highest for low-risk individuals, and decreased significantly with the number of risk factors. The authors concluded that a favourable cardiovascular risk profile in middle age is associated with better QoL and lower risk of disease in older age; the fewer the risk factors, the higher the QoL.

Daviglas M L *et al. Arch Intern Med* 2003; **163** :2460- 2468.

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