

## HEALTH NEWS HIGHLIGHTS MARCH 2012

### Healthcare in South Africa – Recent Comments

On March 30, **Mr David Lewis**, head of the newly-founded Corruption Watch, was quoted by *The Cape Times* that probably the greatest number of complaints the organisation has received, since it began eight weeks ago, dealt with corruption in the healthcare system. **A report on the “corruption free-for-all” in SA’s healthcare system, will be released soon.**

**South Africa is very good at debating everything and not implementing anything**, Dr Olive Shisana, a key advisor on South Africa's National Health Insurance (NHI), recently said.

**Mr Adrian Gore**, renowned businessman and CEO of Discovery Holdings, has proven that he is prepared to put his money where his mouth is: He **stopped taking on Government in public and has adopted a more conciliatory** approach. Because, says Gore, there is **more to be gained by working closely** with Government on its plans to implement NHI.

Although it is a well-known fact that most of the health departments of provincial governments are in a sorry state, with corruption, overspending, unpaid bills and appalling conditions in clinics and hospitals and not nearly enough professionally qualified staff in the order of the day, **the Western Cape’s healthcare system seems to be operating successfully!** No wonder Health MEC, Theuns Botha has proposed that other provinces adopt the Western Capes’ **alternative solution to NHI: a universal healthcare/comprehensive medical care for all built on a primary healthcare basis.**

**Maybe the latter demonstrates that there might be light at the end of South Africa's very dark healthcare tunnel: but arriving there will demand an enormous effort from the “rainbow nation” as a whole.**

As Dr Chris Archer, chairman of the South African Private Practitioner Forum recently called the **NHI “the wrong cure for a misdiagnosed problem”**. He added that the NHI, which was "a funding mechanism", could not deal with the problem of poor service delivery.

The following health news highlights illustrate many examples of the enormous hurdles in the way of a better healthcare system. To name only a few: Health experts say South African medical professionals are flooding foreign markets while **452 government hospitals are on the brink of collapse**; the public health sector has a total of **44 780 vacant posts for professional nurses** and **10 860 for doctors**; pharmaceutical companies are complaining about **the backlog in the registration of products at the MCC** while a shortage of an essential AIDS drug reveals shortcomings in the Department of Health's medicines supply chain management.

## HEALTH NEWS: MARCH 2012

### INDEX

1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH
2. NEWS ON HIV/AIDS, TB, MALARIA & COMMUNICABLE DISEASES
3. DOCTORS, NURSES, HOSPITALS & TRAINING
4. MEDICAL SCHEMES
5. PHARMACEUTICALS
6. FINANCIAL NEWS
7. GENERAL NEWS

#### 1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

##### *State 'should be primary healthcare provider'*

*Business Day, 29 March 2012*

At the recent Health Leadership Dialogue Series in Sandton, **South African Private Practitioner Forum chairman Dr Chris Archer** called the NHI **"the wrong cure for a misdiagnosed problem"**. He said **the public healthcare system needed "rehabilitation"** based on its effectiveness in comparison with the amount of money allocated to it, meaning **"political considerations are taking precedence over economic reality"**. He added that the **NHI, which was "a funding mechanism", could not deal with the problem of poor service delivery**. Archer also defended the cost of private healthcare, saying it was of high quality and, when looked at from an international perspective, was very affordable. Health Minister Aaron Motsoaledi said NHI was **"not about competition" with the private sector**, but was in line with a movement away from "voluntary prepayments" such as medical insurance.

##### *State healthcare in crisis*

*The Sunday Times, 25 March 2012*

**South Africa's 452 government hospitals are on the brink of collapse**. They have a shortage of medical professionals; life-saving equipment; food for patients, and funds to renovate dilapidated buildings and infrastructure. The crisis comes as the government conducts **an audit of its 4 200 health facilities in preparation for the NHI system**. **The latest statistics provided by Medpages**, a firm that compiles an authoritative database for healthcare in SA, show that the country has only: 22 826 general practitioners and specialists, of whom about 70% are in the private sector; 46 910 allied health professionals including physiotherapists, anaesthesia technicians, clinical psychologists, neurophysiologists and optometrists; 25 071 hospital administrators and CEOs; and, 5 055 dental practitioners.

**Government statistics indicate that the public health sector has a total of 44 780 vacant posts for professional nurses and 10 860 for doctors**. The cost to fill these posts is about R26,2-bn a year in

salaries. The figures are based on calculations by economics consultancy **Econex, which had direct access to the government and the Treasury's database**. The database also shows that SA's eight medical schools produce a combined total of only 1 400 general practitioners each year.

***NHI pilot will focus on district systems; Government takes first steps to decent healthcare for all***  
*Business Day, 23 March; Business Report, 23 March, The Times, 23 March 2012*

Health Minister Aaron Motsoaledi has announced the 10 pilot sites for the NHI pilot project due to start next month. The sites - which cover 20% of SA' population - are being **funded by a R1-bn conditional grant announced by Finance Minister Pravin Gordhan last month**. The EU has **donated an additional R1,26-bn**. **A total of R150-m was allocated for the 2012-13 fiscal year**. The 10 districts are: OR Tambo in the Eastern Cape, Vhembe in Limpopo, Gert Sibande in Mpumalanga, Pixley ka Seme in the Northern Cape, Eden in the Western Cape, Dr Kenneth Kaunda in North West, Thabo Mofutsanyana in the Free State, Tshwane in Gauteng, and uMzinyathi and uMgungundlovu in KwaZulu-Natal. KwaZulu-Natal has volunteered to pilot a third district from its own budget and has allotted R110-m. **"Service packages"** will be delivered by **teams of specialists, as well as contracted private healthcare practitioners** who would work to improve service delivery and referral mechanisms. Private practitioners will be paid by the DoH for working "at least three or four hours" in a local clinic.

### Reaction

***Prof Alex van den Heever, Wits health economist:*** As the NHI green paper remains unclear on what form the NHI system would take, it is **questionable what lessons could be learned from pilot projects**. The **contracting of private doctors**, for instance, had "nothing to do" with NHI, and was **an unrealised idea mooted in a 1997 white paper**. The fact that no mention is made of the establishment of the district health authorities was also of great concern as this platform was necessary to engage with the private sector.

***Me Mariné Erasmus, a senior healthcare economist at Econex:*** A step in the right direction. However, to be effective, necessary **data should be collected from the beginning**. Proposals in the NHI green paper should be tested in order to identify shortcomings in all proposed systems.

***The SA Medical Association:*** The best **platform from which to evaluate the master plan**, and to react to and rectify "issues that might emerge". The critical issue was **what kind of level of financing would be required and where financing for the full implementation of the scheme would come from as well as staffing for the project**.

***National Education Health and Allied Workers' Union's spokesman Sizwe Pamla:*** R1-bn is not enough funding for the roll-out. Although the union is against the implementation of the NHI in phases, it will be patient in order to get to a point where SA had a fully adequate health system.

***The Treasury is planning to release a discussion document by the end of next month*** outlining Government's **proposals for meeting the funding gap for NHI**, which it estimates will run to R6-bn for the 2014-15 fiscal year. Options include a payroll tax and an increase in VAT.

***Queue starts to move; Western Cape's NHI prejudices cause for concern; WC punts its model for public healthcare***

*The Sunday Independent, 18 March; The Financial Mail, 2 March; Business Day, 27 March; The Cape Times, 27 March 2012*

Although the Western Cape (WC) does not support the NHI in its current form, it **will still participate in the pilot projects**, according to health MEC Theuns Botha. Meanwhile the WC has proposed an **alternative solution to NHI - universal healthcare/comprehensive medical care for all**. This is **built on a primary healthcare basis** - similar to the structures operating in the province at present - where patients are **referred to regional and specialised facilities according to their needs**, and government provides transport. This primary healthcare focus has resulted in **fewer queues and no chronic shortage** of basic medicines and supplies. It has also been able to maintain a **good track record of managing its balance and paying service providers**. **Partnership with the private healthcare sector is very important**, Botha says. The **gap between the need for health services and the available resources** remains a challenge and increases the **need for efficiency, working smarter and reprioritising services**.

**However, in the other provinces healthcare seems to be on the brink of a total collapse. Gauteng has unpaid bills from service providers amounting to billions of rand.**

In reaction to Botha's view the **SA Medical Association** in the Western Cape (Dr Mark Sonderup) voiced its concern about whether the province can run this health reform project successfully and without prejudice.

***Quality: new buzz word in ANC policy - editorial commentary***

*Business Day, 6 March 2012*

The ANC's switch in focus from **broadening access to public services to raising their quality** is evident throughout its **education and health policy document**, released on March, 5. Education and health are central to the **policy proposals** to be discussed at the ruling party's **policy conference in June** and finalised at its year-end **conference at Mangaung**, ahead of **general elections in 2014**. There is a consolidation of the ANC's plan to introduce a NHI system, with several revenue collection and management proposals, and the **controversial proposal to switch responsibility for "central hospitals" from the provinces to the national department** as part of a decision to 'fast track' the implementation of NHI. (Also read: **turf war** in 3. p5)

The ANC's discussion document on health and education is available for download at:

<http://www.anc.org.za/docs/discus/2012/educationr.pdf>

## 2. NEWS ON HIV/AIDS, TB, MALARIA & COMMUNICABLE DISEASES

***Brics help improve health in poorest countries; SA a hub for research on infectious diseases; ANC calls for new health policy***

*Janice Roberts: Business LIVE, 27 March; The Times, 2 March 2012*

**South Africa is a hub for research and development as well as clinical research** focused on infectious diseases, according to a report: *How Brics are reshaping global health and development*.

This is due to **SA's well-established clinical infrastructure, high prevalence of HIV/AIDS and TB, and local expertise**, the Global Health Strategies initiatives (GHSi) report added. SA's response to HIV/AIDS and TB has had a broad influence on global health, particularly in terms of clinical research, advocacy and policy.

The report states that the Brics countries, Brazil, Russia, India, China and SA are injecting new resources, innovation and momentum into **efforts to improve health in the world's poorest countries**. **China has been a leader on malaria treatment** in Africa while **Brazil and India** are contributing to **HIV/AIDS treatment and vaccines**. Meanwhile the ANC has proposed that Government should **force partners to reveal their HIV status to each other and their families**. The notification would stay confidential and would help Government **collect reliable statistics on HIV infection rates**, which will be used for planning purposes.

***Work on new TB vaccines; Study deflates hopes for daily TB pill; Mineworkers worst hit***  
*Business Day, 9 +22 March; The Cape Times, 23 March; Health-e News Service, 22 March 2012*

Hopes of **preventing the spread of tuberculosis (TB) among mineworkers** by giving everyone a daily pill have been **dashed**, after a **South African study had found the strategy did not work**. The Thibela TB study, conducted by researchers from the Aurum Institute and the London School of Hygiene and Tropical Medicine, included **gold miners from 15 SA mines**. Due to their **migration patterns, exposure to silica dust** in mines (causing silicosis) and **sexual activities**, SA mineworkers are worst affected by TB. **In South Africa, 60% of TB patients** (also called HIV/AIDS' "terrible twin") are **HIV-positive**.

As long as people live **in overcrowded, poorly ventilated little houses, eat unhealthy food and fail to access health services**, TB will flourish. However, scientists hope to have an **effective vaccine against TB by the end of this decade**. Recently the **Bill and Melinda Gates** Foundation announced that it would give **\$220m to the field over the next five years**.

#### ***Child disease clinic for Cape Town***

*The Cape Argus, 29 March 2012*

**Cape Town's Red Cross Children's Hospital** is upping the ante in its fight against major child killers, tuberculosis and diarrhoea by building a **R30 million specialist infectious disease clinic**.

#### ***Half of all cancers are preventable; An aspirin a day can keep cancer at bay***

*Reuters, 21 March; The Citizen, 28 March 2012*

**Half of all cancers could be prevented if people just adopted healthier behaviour**, according to an article in the **US journal Science Translation Medicine**. **Smoking is blamed for a third of all US cancer cases** and being **overweight leads to another 20%** of the deadly burden that costs the United States about \$226-bn per year in healthcare expenses and lost productivity.

On a more positive note: Three new studies led by Peter Rothwell of Britain's Oxford University, found **that aspirin has a short-term benefit in preventing cancer, and that it reduces the likelihood that cancers will spread to other organs by about 40% to 50%**.

### 3. DOCTORS, NURSES, HOSPITALS & TRAINING

#### ***Hospital plan to address shortcomings***

*The Star, 1 March: Business Day, 1 March; The Star, 2012*

The National Department of Health issued the key objects of its policy on the management of hospitals. They are: laws "to **improve the functionality of hospitals**"; the **appointment of "competent and skilled managers"**; "**decentralisation of management**"; "the **development of accountability networks**"; and **training for management**. All public hospitals will be classified according to **five levels**: district, regional, tertiary, central (including academic hospitals or specialised (including psychiatric, rehabilitation and TB hospitals). The **policy includes a job description for a hospital CEO** as well as **number of beds and services offered by hospitals**.

#### ***Begging bowl out for health***

*The Sunday Times 25 March 2012*

Government needs an **additional R38-bn a year to fill all vacancies in public hospitals and clinics countrywide, according to a report released by the Department of Health**. The total of **106 518 vacancies around the country** include those for 44 780 nurses, which would cost the state R17,6-bn, and R8,6-bn for 10 860 doctors. Hiring 3 491 specialists would cost R3,6-bn; R496-m would be needed for the 921 dental practitioners; R204-million for radiographers and R305-million for physiotherapists.

**The department's budget** - which includes infrastructure projects, salaries and medical supplies - **stands at R121-bn for the 2012/13** financial year.

The figures were **calculated by economics consultancy Econex**, using information from the **government's human resources system** and the national **Treasury's database**. The report puts the average state doctor's salary at R796 822 a year; about R1-m for a medical specialist; R538 904 for a dental practitioner; R411 516 for a pharmacist; R393 591 for a nurse; R284 592 for a physiotherapist; and R126 316 for a radiographer. Health experts say **South African medical professionals are flooding foreign markets** because of relatively poor salaries and poor working conditions, including a lack of resources and equipment to provide quality healthcare.

#### ***R9bn needed to fill Eastern Cape health posts; Gauteng Premier finds queues at health facilities; Gauteng hospitals get more direct power in drastic move; Mpumalanga report details of collapsing services; Shot in the arm for Eastern Cape hospitals; Public hospitals in Gauteng sick and tired***

*Business Day, 15 March; 12 March; The Sunday Times, 25 March 2012*

The **Eastern Cape** health department needs an **extra R9-bn** to fill its 27 267 vacant health posts. **Limpopo, being the worst off, has a R14-bn shortage with 39 653 vacant health posts**. Meanwhile **Eastern Cape** health department has spent more than R1-bn rebuilding and renovating some of its 82 state hospitals. More hospitals need to be renovated, and – following a strike – nurses were guaranteed a R5,5-m pay back for night duty dating back to 2007.

**Gauteng:** After a visit to **overcrowded clinics**, Gauteng Premier Nomvula Mokonyane said it indicated that residents **still had confidence in primary healthcare services** in the province. Gauteng health MEC Ntombi Mkgwe said overcrowding could be reduced if a strategy is adopted to **prioritise attending to elderly people and young children**. Earlier in March Mokonyane said the **province's health department is overburdened** due to an **influx of patients from neighbouring provinces and other countries**. Meanwhile conditions at Chris Hani Baragwanath in Soweto are still being described as "disgusting"; and cancer patients at Steve Biko Academic in Pretoria are turned away because two radiation machines were not working. Complaints about Gauteng hospitals include; a **shortage of equipment and medicines**, a **shortage of supplies** (including food, medicine, clean linen, gloves, aprons); dirty linen; and unhygienic conditions.

**Department heads of hospitals** have been given the **power to buy medicine and equipment directly from medical suppliers** in a **short-term arrangement** to bring an end to shortages after an outbreak of Klebsiella. Meanwhile **dismissal** of Dr Claude Muzanga, Gauteng's **head of procurement**, was announced following forensic investigations against him.

A report compiled by the Mpumalanga legislature identifies the **shortage of nurses and doctors** as the most important issue. The Piet Retief Hospital has 315 vacancies for medical and non-medical staff; some of the clinics do not have full time doctors; and others lack the necessary equipment.

#### ***NHI Cape hospital turf war: Butting heads on heads; 'No more imported nurses'***

*The Cape Argus, 27 March; The Weekend Argus, 4 March; The Financial Mail, 9 March 2012*

In reaction to the ANC's latest draft policy on healthcare, the Western Cape's **MEC for health, Mr Theuns Botha**, has **vowed to go as high as the Constitutional Court** to ensure that control of two of Cape Town's major tertiary hospitals, Groote Schuur and Tygerberg, is **not shifted to the national government**. He asked why "well-functioning, good hospitals" should be **nationalised** "so they can end up like the rest of the hospitals under the national government". **Other hospitals** mentioned in the document are **Chris Hani Baragwanath Hospital** in Soweto, and **King Edward VIII Hospital** in Durban. At the end of February **92 positions for chief executive officers of hospitals were advertised** as part of a government plan to improve primary health care. Botha indicated that no provincial hospitals in the Western Cape would be affected since they had competent chiefs. **The alleged politically motivated appointments of public hospital CEOs** are viewed by some as **the root cause of the decline in basic hospital functions**.

Botha also announced that his department **was negotiating with the private sector to stop importing nurses to the province** to assist with nurse training as **his department was producing enough qualified nurses from its training institutions**. WC now has the required number of professional nurses and it makes sense for the private sector to absorb some of the local nurses.

## **4. MEDICAL SCHEMES**

#### ***Draft Demarcation Regulations released for comment***

*BusinessLIVE, 6 March 2012*

The draft Demarcation Regulations which seek to find a **better balance between medical schemes and health insurance products**, also address the risk of **possible harm caused by health insurance products** drawing **younger and healthier** members **away from medical aid schemes to health**

**insurance products.** By pooling healthier and sicker individuals **cross-subsidisation** is made possible through medical schemes. **Health insurance products**, on the other hand, operate on the basis that the **policy holder pays a premium** that is determined by the policy holder's **age, health status or income.** The Treasury said the regulations will ensure that health and financial sector policy objectives were aligned, which was critical to prevent regulatory arbitrage between health insurance and medical scheme products in South Africa.

The draft regulations are available for download from:

<http://www.medicalschemes.com/files/Acts%20and%20Regulations/MoFOnDemarcationSTRegulations.pdf>

***Government to cut medical top-up and gap cover; Gap-cover health insurance under scrutiny; 'No evidence' that gap cover subverts medical schemes; Gap cover ban 'a blow to scheme members'; Patients at risk if medical gap cover is outlawed;***

*Personal Finance, 3 +10 March; Business Day, 8 March; Business Report, 19 March; BusinessLIVE, 6 March 2012*

Many medical scheme members who **top up their cover with gap cover policies** may have to **consider upgrading their medical plans** after the government indicated that it wants to **ban these policies.** **Gap cover policies typically pay out when there is a shortfall** between what a medical scheme pays a doctor for a procedure and what the doctor actually charges. **Top-up cover** – that pays out when **medical scheme benefits or annual limits are exhausted**, **dental insurance** ( fixed benefits for specific dental procedures), and **health policies – that provide top-up cover** - and daily preventative healthcare services could also be outlawed. The draft Demarcation Regulations, which seek to find a **better balance between medical schemes and health insurance products**, also address the risk of **possible harm caused by health insurance products** drawing **younger and healthier** members **away from medical aid schemes to health insurance products.** The draft regulations have been published for comment until April 23. According to the Treasury the regulations represent an important step in ensuring that **health and financial sector policy objectives were aligned**, which was critical to prevent regulatory arbitrage between health insurance and medical scheme products in South Africa.

**According to the regulations, hospital cash plans will be allowed to continue**, but only as **income protection policies**, with limited benefits. A product **disallowed by the regulations, will not be renewable** when its term expires. Government also plans to amend the **definition of a medical scheme** to deem **any policy that helps pay for healthcare services** as doing the business of a medical scheme. However, two policies - those that pay the costs of **HIV-related testing and HIV and AIDS treatment on an employee group basis** and those that cover the costs of **frail care** – **will still be allowed.** The regulations also seek to address **concerns** that certain health insurance products, which provide **similar benefits to medical schemes**, could **harm medical schemes by attracting younger and generally healthier members away from schemes.** It also addresses the fact that **health insurance products are not subject to the close scrutiny faced by medical schemes**, which have to comply with the Medical Schemes Act.

#### **Reaction:**

**Prof Alex van den Heever of Wits** says the **regulations do not go far enough.** The **Council for Medical Schemes** - rather than the registrar of the Financial Services Board – **should have the final say** over which products are harmful.

**Jonathan Broomberg**, CEO of Discovery Health, says schemes are **being undermined in their ability to provide lifetime cover**, which is based on those who are healthy subsidising those who are ill over time. (The major users of gap cover products are Discovery Health Medical Scheme members who belong to options that offer to reimburse specialists at only 100% of the Discovery Health rate, according to medical scheme brokers.)

**The Board of Healthcare Funders** argues that **consumers need the protection** offered by gap-cover products. BHF spokeswoman Heidi Kruger called on the Minister to **urgently regulate providers with regard to healthcare pricing**.

**The National Treasury** said the regulations aimed to **address the risk of possible harm caused by health insurance products to medical schemes and their risk pools**.

**Richard Blackman**, CEO of Day1health, says the draft regulations **restrict one's right to choose** between a **medical scheme and a hospital cash plan**. Day1health provides healthcare cover for people who earn less than R7 000 a month for R226 a month.

**Tiago de Carvalho**, MD of underwriter **Ambledown**, says prohibiting products that provide hospital cover after an accident will place a **greater burden on the public healthcare sector**.

**Peter Hyman**, director of **Complimed**, another provider of gap and top-up cover, predicts that providers of gap cover policies will be able to **adapt their benefit designs** to fall in line with the regulations if the regulations are promulgated, **Michael Settas**, director of gap cover provider **Xelus**, says blaming gap cover providers for "the mess" in the private healthcare industry "is **hypocritical and completely ignores the consumer**, who has to bear the brunt of poor policy decisions". Should the government proceed with the regulations in their current form, there will be a huge **public backlash or a legal challenge over the constitutional right of consumers** to insure themselves against financial risks, **Settas** says.

**Richard Eales**: Manager, **Corporate Risk Solutions at Guardrisk**, says **no evidence** has been presented to show that gap cover products **undermine medical schemes**. The Judge in the 2008 court case in which the Registrar of Medical Schemes **attempted to close down Guardrisk's gap cover products** had noted the **lack of evidence that these policies undermine schemes**, and to date no evidence has been presented, he says. Guardrisk's most frequent claims are for older people.

**Editorial Comment: Potential state patients all; Sceptical judges question Obama health law**  
Reuters, 27 March; Business Day, 20 March 2012

The Treasury's move to restrict the availability of medical insurance gap cover products is ostensibly **aimed at stabilising the medical schemes market**, which it **believes is being undermined by the loss of younger, healthier members, who are increasingly opting for cheaper insurance products to cover medical emergencies**.

**Medical insurance products were introduced in response to a legitimate need**; banning them by fiat will not ensure that need is fulfilled. Some providers suspect the reason behind the Treasury's move is to serve as **an incentive for medical scheme members to give up private healthcare**.

**\*In the USA** 26 of the 50 states and a small-business trade group are **challenging pres. Barack Obama's 2010 healthcare law** of which the **key requirement is that most people obtain health insurance or face a penalty.**

### ***Medical savings account should earn interest***

*Personal Finance: 3 March 2012*

Medical schemes **not paying interest on medical savings account contributions at bank deposit rates** have been instructed to **ring-fence the interest earned on these funds and to credit it to members' accounts by the end of this year.** Schemes should ensure that the **interest earned on savings account balances** is not used by the scheme but **held in a suspense account until systems have been developed to allocate the member's portion of the interest to their savings account.** Schemes facing additional costs, warranting a **contribution increase, should present evidence** of this to the CMS. The council's September 2011 instruction to schemes on how to deal with savings account monies was based on a 2007 High Court judgment that prevented the liquidators of Omnihealth Medical Scheme from using some R33-m in members' savings accounts to repay the scheme's creditors.

### **Reaction from schemes:**

***The Board of Healthcare Funders (BHF)*** says it has taken legal opinion and is of the view that the CMS circulars go beyond the ambit of the Omnihealth case. ***The CMS says*** the Financial Institutions (Protection of Funds) Act requires schemes to open a **separate account in the name of the scheme.** These funds do not form part of a scheme's assets and cannot be used to pay for a scheme's expenses or claims against its risk benefits.

***The South African Institute of Chartered Accountants' medical schemes project group*** said if **medical savings account funds were no longer regarded as a scheme asset,** this could affect the **calculation of schemes' solvency ratios.**

However, in its latest circular, the **CMS says solvency ratios will continue to be calculated based on contributions that include those made to medical savings accounts.** Changes to the way in which savings contributions are accounted for do not change the financial risk of medical schemes.

***Medical aids to pay for joint surgery; Obesity an expanding problem; UK companies cut calories***  
*Business Report, 5, 6 March; Netdoctor.co.uk, 27 March 2012*

**Obese patients,** who have **been victims of discrimination by medical schemes** refusing to pay for certain surgery benefits, will **now be covered** following a ruling by an independent appeal panel over **funding for joint replacement surgery.** This follows a battle between all medical schemes contracted to manage care group Medical Services Organisation (MSO), which include Medshield and Spectramed, and the Council for Medical Schemes (CMS).

**MSO and Medshield** argued that **surgery was far more risky** when performed on an obese patient. The appeals board found that the **protocol that MSO had been applying fell foul of the regulations.** Meanwhile The Heart and Stroke Foundation of SA claims **obesity and excess weight** are the major contributors to **cardiovascular problems.**

**\*News from the UK** is that some of the **best-known British brands and food and drink manufacturers** had signed up to a **calorie reduction pledge** under the Responsibility Deal. It is hoped that five billion calories can be cut from the nation's daily diet in a bid to tackle obesity.

***Premium rise is only option - Medshield***

*Business Report, 13 March 2012*

A staggering **61,93% premium increase on one of Medshield's medical aid options** has left members having to pay more for medical expenses every month. Medshield upped monthly premiums on one of the income-based options from R1 392,25 to R2 254,50 for a single 80-year-old pensioner receiving chronic medication for a heart condition. Medshield said the **income-based options had proven difficult to sustain** and therefore the scheme decided to discontinue the low-income bands of two of its offered options in line with section 33 of the Medical Schemes Act.

***State to shift pensioner group from Medihelp to cheaper Gems***

*Personal Finance, 10 March 2012*

National Treasury has decided to **move a group of state pensioners** who retired before 1992 from Medihelp medical scheme to the **Government Employees' Medical Scheme (Gems)** with effect from April 1. They will be moved onto the Gem's most comprehensive option, Onyx. Medihelp Plus costs R4 278 a month for a principal member, while the Onyx option ranges from R2 124 to R2 388 a month. Medihelp's CEO, Anton Rijnen, says the migration of the pensioners to Gems will have a **positive effect on the average age of Medihelp's members**.

***Union scheme calls for tighter regulation***

*Personal Finance, 10 March 2012*

A municipal workers' union (Samwu) and its medical scheme have called on Cosatu to support its demand that the government **intervene to ensure the survival of medical schemes in the run-up to the introduction of NHI**. **The union has asked for:** the exemption of healthcare from the Competition Act; that healthcare be removed from the market and assume its legitimate place as a social need; the regulation of healthcare costs and the immediate reinstatement of the National Health Reference Price List as an interim measure; ministerial intervention into the interpretation of the PMB regulation under the Medical Schemes Act; and, a government commission of inquiry into the actions of the Registrar of Medical Schemes.

***Discovery: Less lapsing, longer living; Discovery's founder sees long life and healthy growth***

*Business Day, 15 March; The Financial Mail, 2 March; BusinessLIVE, 24 March 2012*

Discovery Holding's CEO, Adrian Gore, has **stopped taking on the government in public and has adopted a more conciliatory** approach as he believes there is **more to be gained by working closely with the government** on its plans to implement NHI. Gore says Discovery Health's 20%-a-year earnings growth over the past 20 years is sustainable. Although **membership has raised by 7% to 1,19m principal members** in the six months to December, it faces **stiff competition** from **Medscheme and MMI'S Metropolitan Health**, which now includes the Momentum open scheme.

## 5. PHARMACEUTICALS

### *Cleaning up their act*

*The Financial Mail, 30 March 2012*

**Corporate events disguised as "meetings" and corporate gifts** given in appreciation for business and sales could be **on the way out** in the **pharmaceutical and medical device industry**. The Marketing Code Authority (MCA) recently signed a memorandum of understanding to this effect with nine organisations. The **MCA will be a watchdog for fair play** and a vehicle for the public and health professionals to report **untested "miracle" product advertising, illegal advertisements for schedule 2 medicines**, defamatory adverts, and sponsorship of medical professionals or sports events unrelated to their work or the product.

### *Generic drugs take the fight to original brands*

*Business Report, 29 March 2012*

According to the **IMS Health 2011 annual report**, **more than 50% of South Africans** now opt to use **generic medicines** rather than a brand name prescription drug. The actual generics volume sales **in 2008 were above 45%**. Local pharmaceutical firms have voiced concerns over the **tightening competition from generic medicine**.

### *Taking on Big Pharma*

*Reuters, 15 March 2012*

Experts say that **India's move to strip** German drug maker **Bayer of its exclusive rights to a cancer drug** has set a **precedent that could extend to other treatments**, including modern HIV/AIDS drugs, and is a major blow to global pharmaceutical firms. The Indian Patent Office has **effectively ended Bayer's monopoly for its Nexavar drug** and issued its first-ever compulsory licence allowing local generic maker Natco Pharma to make and sell the drug cheaply in India.

**Other patent rulings are imminent**. Companies like **Pfizer, GlaxoSmithKline and Novartis are eyeing India and emerging markets, like China**, as a **growth opportunity** but worry about **property protection in a country that is also a leading source of cheap copycat medicines**.

### *Slow registration of drugs drags on profit; Cipla slumps on MCC approval delays; Litha forced to shut down cardiac unit*

*Business Day, 28 March; Business Day, 16 March; The Financial Mail, 16 March; Business Day, 20 March; Business Report, 20 March 2012*

**Cipla Medpro** announced that it had been **forced to delay new product launches** because of **registration backlogs at the Medicines Control Council (MCC)**. Cipla managed to get only 20 products registered with the MCC in the 12 months, and had **273 dossiers pending**. In 2011 Cipla lost at least R15-m due to the failure to register new suppliers of active pharmaceutical ingredients.

**Adcock Ingram has 656 dossiers pending approval**, almost two-thirds of which have been with the MCC for over two years.

**Litha Healthcare Group** CEO Selwyn Kahanowitz said that to grow, his company has had to resort to **acquiring rivals that had already secured approval for products**. Earlier in March Litha was forced to shut down its fledgling cardiac unit, due to delays in registering new products with the MCC. Litha has **60 dossiers awaiting approval**.

**Pharma Dynamics had approximately 300 dossiers** awaiting registration. In Australia the average registration time was nine months.

**About 1 500 applications were awaiting approval**, most of them for generic medicines. The DoH head of financial planning, Anban Pillay, said there was **not enough staff to cope** with the workload. Pharmaceutical companies complain that the **MCC does not use provisions in its own policy guidelines for "abbreviated registration"**, which recognises work done by regulators such as the US Food and Drug Administration and the European Medicines Authority.

## 6. FINANCIAL NEWS

### ***Aspen's revenue up 31% over half year***

*Business Day, 8 March: Business Report, 8 March 2012*

Pharmacare's revenue rose 31% to R7,5-bn; and diluted headline earnings per share from continuing operations climbed 22% to 305,2c. Revenue from the local division fell 11% to R2,9-bn after it was hit by a slump in sales of AIDS drugs to the government, a month-long strike in July 2011, and generic competition in its biggest brands, Seretide and Truvada.

### ***SA firm cuts cost of making HIV drug***

*Business Day, 15 March 2010*

South African drug development company **ithemba Pharmaceuticals** has devised a **cheaper way to make the widely used AIDS drug tenofovir** and has identified several promising **treatments for tuberculosis (TB)**, according to Emory University's Prof Dennis Liotta.

### ***Pfizer announces co-promotion deal with Specpharm***

*The Times, 23 March 2012*

Pfizer South Africa's Biopharmaceutical Division has contracted the services of Specpharm to **co-promote a total of 22 of its pharmaceutical products within the private market**. The deal is expected to rake in revenues in the region of R120-m per annum over a five-year contractual period.

### ***Glaxo to sell several brands to Omega***

*Reuters via Business Day, 16 March 2012*

**GlaxoSmithKline** has agreed to sell several of its **over-the-counter healthcare brands in Europe to Belgium's Omega Pharma for €470m**, while delaying the sale of its weight-loss pill Alli. Net cash proceeds from the sale to Omega, expected to be £310m, would be returned to shareholders this year, Glaxo said.

## 7. GENERAL NEWS

### ***Transnet launches new health train***

*SAPA 12 March 2012*

Transnet has launched its **second health train, the Phelophepa II, costing R82m**. The trains, crewed by medical specialists including a number of final year students, provide **primary healthcare, dental, psychological and optical services**. The trains operate from January to September every year and cover vast areas where primary healthcare facilities are under pressure.

### ***Surgeons sound alarm about hip surgery; Consumer Reports taps ire over bad medical devices***

*Business Day, 13 Marc; Reuters, 13 March 2012;*

**South African surgeons** have added their voice to the **growing global concern over the safety of "metal-on-metal" hip implants**, after research has shown these devices have **high failure rates** and can cause other health problems. Johnson & Johnson subsidiary Depuy **recalled its metal ASR hip systems worldwide in August 2010**, due to a **high rate of repeat surgeries**.

**News from the USA** is that Jim Guest, president of *Consumer Reports*, claims that millions of **medical devices, including artificial hips, contact lens solutions, heart stents, and pacemakers** were being recalled and the vast majority of recalled products were **never safety tested in humans**, because the manufacturers claimed they were **"similar" to products already on the market**.

### ***SA scientists generate stem cells from adults***

*Business Day, 22 March 2012*

The Council for Scientific and Industrial Research (CSIR) has announced that scientists in SA have generated **"induced adult pluripotent stem cells" from adult skin cells** and can be prompted to grow into any type of adult cell, such as those in the heart or brain.

### ***Finger-pointing as state runs out of AIDS drugs***

*Business Day, 30 March 2012*

A **shortage of an essential AIDS drug** this week has revealed **shortcomings in the Department of Health's medicines supply chain management**, casting the spotlight on one of the many service delivery problems the pilot sites for NHI will have to tackle.