

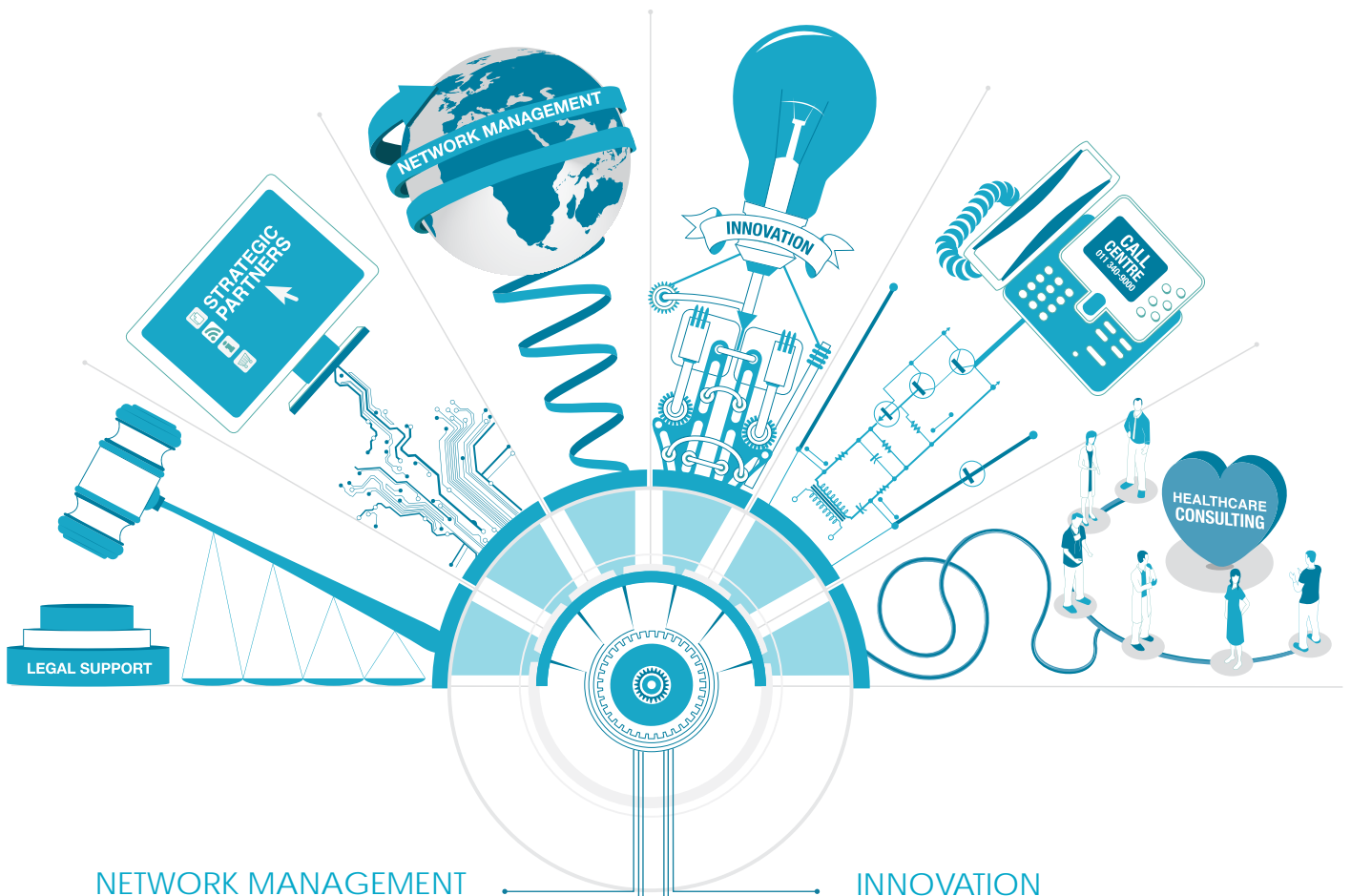
# Paediatric

# NEWS

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May issue 2013





## NETWORK MANAGEMENT

At HealthMan, we provide administration and company secretarial support to specialists and other provider network companies and societies. We are instrumental in negotiating with medical schemes, medical scheme administrators, Managed Care Organisations, pharmaceutical companies and Council for Medical Schemes (CMS) on behalf of specialists and other disciplines. We offer support for general practice management issues, Prescribed Minimum Benefit (PMB) queries, coding queries from scheme administrators and from practices and member communications and newsletters.

## STRATEGIC PARTNERS

HealthMan's strategic partners provide additional value add services to the HealthMan client base. These include amongst others: E2 Solutions, Prosper Financial Services, CITADEL, Healthbridge, Healthfocus and GoodX. Their information can be found on their respective websites, or by enquiry from the HealthMan office.

## LEGAL SUPPORT

HealthMan provides legal support to South African Private Practitioners Forum (SAPPF), societies and management companies on various regulatory reforms by Government, and legal challenges by third parties such as the Board of Healthcare Funders (BHF). In the High Court, we have assisted in settling many civil disputes, loss of income and malpractice claims. Once, we settled a claim in the amount of R22 million in favour of one of our specialist clients. We also actively assist our clients in forensic reviews against them by medical scheme administrators and participate in the BHF Fraud Management Unit. Our legal support includes a review of new policy documents issued by government, such as National Health Insurance (NHI) and assisting in formulating responses thereto.

## INNOVATION

HealthMan is highly knowledgeable about the health care industry. We have been involved in the establishment of most Specialist and other provider management groups including SAPPF and IsoLesO Optics. We provide legal challenges support and are on the forefront of research and publications in the health care spectrum. We also manage alternative reimbursement models, which clearly puts us as the leader in this market segment.

## CALL CENTRE

The HealthMan Optometry Call Centre manages all IsoLesO Optics Optical Contracts. We manage over 400 000 medical scheme lives. The HealthMan Multi-Disciplinary Call Centre manages medical scheme claim administration problems and is the only multi-disciplinary service of its kind in South Africa.

## CONSULTING

As HealthMan we consult to Medical Practitioners, their respective societies and management companies in order to get the most accurate information possible for our clients. We provide information on a wide variety of subjects such as financial modelling, economic impact studies and data base analysis. We also consult on practice profiling and costing which can help empower doctors and other healthcare professionals. We consult on data mining, claims analysis and the introduction of new coding.

HealthMan is a privately owned healthcare consultancy that has been consulting to Private Practice for 17 years. We aim to promote the professional and commercial interests of both specialist and other healthcare practitioner networks and societies.

@ Visit [www.healthman.co.za](http://www.healthman.co.za) to find out more



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## SIGNIFICANT DEVELOPMENTS UNFOLDING FOR PRIVATE PRACTICE



**Dr Chris Archer, SASOG**  
CEO: SA Private Practitioners' Forum (SAPPF)

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There are two important developments currently unfolding with potentially significant implications for private practice, the first and most pressing being the Medical and Dental Professions Board (MDPB) of the Health Professions Council of South Africa's (HPCSA's) intention to set a guideline tariff in the absence of the RPL – declared illegal by the courts and to date not replaced by the mooted Independent Pricing Commission of the Minister of Health.

The second is the Market Enquiry into the Private Health Industry now get underway, (SAPPF is being interviewed on its views on what should constitute the Terms of Reference for the enquiry on 20 May) which will put the spotlight on the private sector and in particular the role of specialists and private hospitals as causes of what the Minister considers to be unjustified high prices being charged by the private sector.

There is little doubt in the mind of the author that the two events alluded to are interlinked and the linking entity is NHI, for there is no question that for NHI to be successful the private sector will have to be contracted to provide services to NHI patients. However, estimates of what the NHI will cost suggest that this contracting of the private sector will not be affordable to the state at current private sector prices.

Returning to the first matter, it is by now common knowledge that last September the HPCSA attempted to foist on an unsuspecting private sector a new tariff based on the BHF reimbursement tariff of 2006 with a CPI inflator. Fortunately concerted action by SAPPF and others had the tariff withdrawn the following day by the President of Council Pror Sam Mokgogong.

Since then the Tariff Committee of the MDPB under the Chairmanship of Prof Usuf Chikte has embarked on a new process and has called for all interested parties to make submissions on what their group considered important. An

interim feedback meeting was hosted by the HPCSA on the 11th of last month which I and other interested individuals attended. What follows is my report on that meeting which has been distributed to all SAPPF members. A copy of the SAPPF submission (which incidentally was praised very highly by Professor Chitke for its positive tone and constructive suggestions when he came up and spoke to me personally before the meeting started), has been included for information, in the GMG pack for delegates attending today's meeting. SAPPF went to great lengths to involve third party independent experts to draft sections of this report, the reasons for which should become apparent once one reads the report.

### **HPCSA TAKES A STEP TOWARDS CONTROL OF MEDICAL AND DENTAL TARIFF SETTING**

At a stakeholder consultation process meeting in Pretoria on the 11 April the HPCSA reported back on the submissions received on how stakeholders believed the guideline tariff process should proceed. The meeting was chaired by Pror Usuf Chikte, Chairperson of the Medical and Dental Professions Board Tariff Committee who allowed many questions but answered few.

The meeting commenced with a report by Prof Shivani Ramjee, the Head of Actuarial Science at UCT, appointed by the MDPB to advise the council on the matter. Ms Ramjee indicated that she was well qualified to accept the position as she had worked extensively in the health arena and that her particular expertise revolved around construction of price indices, pricing of healthcare risk and management in healthcare delivery.

She noted that that there had been more than eighty submissions and that her analysis was based on the analysis of sixty nine of these. Submissions had been received from many interested sources; medical practitioners including doctors, dentists and psychologists, professional bodies such as SADA, SAMA,

SAPPF, RSSA Surgicom and OSSA, civil society bodies such as the Helen Suzman Foundation, National Consumer Commission, and Section 27, funders such as Medischeme, Discovery, Interdent, VeriRad and Liberty as well as the Competition Commission.

The Ramjee report was an excellent summary of the issues and concerns and she complimented the authors of the submissions, which she thought had been thorough and well prepared and in certain instances had gone beyond the publication of a guideline tariff. (Professor Chitke made a particular effort to thank SAPPF for what he called an excellent submission). There were clear areas of consensus and agreement as well as other areas of a clear divergence of views.

A wide range of issues had been raised around policy, (right of access, sustainability, and problems associated with the current vacuum; PMBs, admin complexity and balance billing), process (Transparency, stakeholder involvement and a fair and rational process and the link between guideline pricing for overcharging and reimbursement), and pricing (strong support for a scientific basis, e.g. practice cost studies, benchmarking against the public sector salaries, ROI, plus the idea of using a median with a dispersion factor, together with strong refuting of the 2006 NHRPL and the use of CPI as an inflator from all quarters).

There was strong agreement about the problems created by the current vacuum and the unsuitability of using the 2006 NHRPL and around the need for a comprehensive consistent and systematic billing guide and around the problems with use of the CPI.

The report highlighted the right of practitioners to earn a fair living and recognised that there was a severe skills shortage in South Africa and that private medical practice had to be sustainable to attract new entrants and to reduce the loss of practitioners through emigration.

The report also highlighted the consumer perspective around the need for affordability and a fair and transparent fee, price awareness and the matter of informed consent.

Ms Ramjee then turned to the issue of the purpose of the guideline tariff; to provide a benchmark for claims of overcharging as well as the concept of a safe harbour for practitioners. This was a different purpose to that of a reimbursement tariff. There was a concern that in the current vacuum any published guideline

will become the reimbursement tariff and this could have adverse implications if it were set either too high or too low.

The issue of what constituted over-charging was highlighted. Should this be anything above the published guideline or should other factors (experience, sub specialisation, patient driven factors such as co-morbidity and complexity and emergency services) be treated exceptionally?

There was broad support for a RBRVS approach with the use of a RVU multiplied by an RCF to determine a fee and for a comprehensive, consistent and systematic coding system. The report then considered possible solutions to the current imperfect situation, such as the establishment of an independent body to deal with new codes, the deletion of obsolete codes and to set suitable relative value units (RVUs) to distinguish between value of different procedures, use of international coding systems and a consideration of the time frames to completion.

The Ramjee report concluded with an overview of practice cost studies, their purpose, advantages and concerns such as the entrenching of current inefficiencies, that they are costly and time consuming and the sampling methodology bias. The question was asked as to where in the distribution curve does one pitch the guideline tariff? An alternative approach was suggested based on using charging norms rather than practice cost norms.

The report back ended with the need to address time lines, issues of governance and what criteria should be used to evaluate the proposals.

All in all this was a balanced nuanced report on the issues raised and augers well for the process to follow. It is recommended that SAPPF tries to arrange a follow up private meeting with Ms Ramjee soon.

Unfortunately by way of contrast, the performance of the Chairperson thereafter could not be classified as balanced, nuanced or impartial. Although Prof Chitke allowed all present several opportunities to raise questions, few of these were answered to any degree of satisfaction and one was left with the impression that in the end, this was nothing more than an elaborate and well orchestrated event, whose prime purpose was for the MDPB to be able to say that the professions had been consulted.

The major criticism was that there was no debate allowed on any of the concerns raised. Two issues in particular needed in-depth discussion. Firstly

**THERE WAS STRONG AGREEMENT ABOUT THE PROBLEMS CREATED BY THE CURRENT VACUUM AND THE UNSUITABILITY OF USING THE 2006 NHRPL AND AROUND THE NEED FOR A COMPREHENSIVE CONSISTENT AND SYSTEMATIC BILLING GUIDE AND AROUND THE PROBLEMS WITH USE OF THE CPI.**

**A FURTHER  
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HAVE A TARIFF  
PUBLISHED BY  
SEPTEMBER  
2013**

the concern around the inappropriateness of the MDPB as both the pricing and tariff setting body for the industry who was also adjudicator judge and jury when it came to matters of overcharging. This is of major concern, given that as it is a body appointed by the Minister, the Board is not independent, and could be subject to political interference. The second concern relates to the lack of protection from a possible Competition Commission enquiry into the participation of individual doctors or their representative bodies, in this process. SAMA would seem to be at particular risk insofar as they are subject to a consent order in which they expressly agreed not to determine, recommend or publish tariffs to their members, or engage in any conduct which directly or indirectly facilitates an agreement between its members. (Consent Order dated:10/02/2004).

A further major concern is around the Chairpersons insistence that they, (the MDPB Tariff Committee), will have completed the review process by July and have a tariff published by September 2013. The SAPPF submission acknowledged that the National Health Act does indeed confer on the Board the right to establish a tariff but our reading of the Act is that the purpose to which the MDPB should put this tariff is confined to that of adjudicating on claims of overcharging brought against a practitioner, and not that it may set a reimbursement tariff for the industry. SAPPF therefore contends that it is neither reasonable nor appropriate that the Board should assume this responsibility. However it seems clear that the Board believes it has a broader mandate, and it was for this reason SAPPF went to great lengths and expense to craft a submission that provided in great detail, the steps we believe are necessary to ensure that the tariff arrived at is fair and transparent and is based on practice costs. Such a process we believe will take considerably longer than the three months envisaged by Prof Chikte to complete.

Because of this concern SAPPF wrote to Prof Chikte last week to suggest an interim solution; namely that the current SAMA DBM be used as the most inclusive coding structure currently available and that the RCF should be calculated using the last published Ethical Tariff published by the MDPB, multiplied by a compounded CPI, plus an additional 20% to make sure that this ethical MAXIMUM tariff was well clear of any reimbursement tariff currently in use by the funding industry. Such an interim tariff would not result in a court challenge by any professional body, nor would it be abused by the

majority of practitioners, as about ninety per cent of private practitioners are locked into DSP arrangements, and historically there has always been a majority of practitioners who have preferred to practice with the certainty of direct reimbursement through charging at medical scheme rates. Prof Chikte has responded to me indicating that he has put this proposal to the Tariff Committee but they have not yet made a decision.

The morning session was followed by a coding discussion (not on the agenda) hosted by Prof Abdul Barday, the HPCSA Ombudsman. He suggested that a coding meeting be set two weeks hence to discuss the current impasse between the 2006 NHRPL, the current SAMA FDBM and codes currently being applied by medical schemes. It was pointed out to Professor Barday that coding is a complex matter, that the MDPB did not have the skills to deal with the matter, and that much more time would be needed to resolve the problems.

The meeting also expressed its concerns as to the Competition Commission's views on such a meeting, and it was agreed that the MDPB first obtain approval from the Competition Commission prior to such a meeting taking place.

The SAPPF preference is for a wholly independent body such as the SACHI entity and it is towards the acceptance and establishment of such a body that we believe our efforts should be concentrated.

## **COMPETITION COMMISSION MARKET ENQUIRY INTO THE PRIVATE HEALTH SECTOR**

Turning now to the market enquiry into private health, it is clear that this process is gathering momentum with the Commission engaging entities with respect to understanding their views on what the Terms of Reference should be. I have been advised by Webber Wentzel that even though it is generally believed that the profession in general and specialists in particular should have nothing to fear from this enquiry, that these initial meetings should nevertheless be approached with due circumspection.

For this reason representatives of all groups affiliated to SAPPF were invited to meet at the offices of Webber Wentzel on Wednesday 15 May to better understand the process that is about to unfold. A report-back on this meeting should be ready for the next issue.

# PMG ADVANCING PAEDIATRICS WEEKEND 2013



The following are reports emanating from the Paediatrician Management Group (PMG) 8th Advancing Paediatrics Weekend 2013 at the picturesque Arabella Hotel and Spa, near Hermanus, from 19 to 21 April.

ARTICLES WRITTEN AND COMPILED BY  
**DR SIMON STRACHAN**

I would like to start by expressing our sincere thanks to Aspen/GSK for their sponsorship of this weekend, their commitment to the PMG and Paediatrics in general is unsurpassed and we thank them again for their generosity and support. 120

Paediatricians attended the whole weekend.

Proceedings commenced with an Anti-Infectives workshop on Friday afternoon. Prof Robin Green introduced the INSPIRATION concept as an Antibiotic Stewardship initiative to improve the treatment of respiratory tract infection.

We must curtail the use of antibiotics and only use them for the correct patient with the correct diagnosis at the correct dose for the correct duration. The correct antibiotic must be chosen based on knowledge of existing resistance patterns and then used for the shortest course possible.

Dr Inge Zietsman joined for the second part of the presentation and highlighted the increasing resistance patterns of organisms emphasising the resistance of the Gram negative Enterobacteriaceae. Beware of the new enemy comprising ESBL, NDM, VIM and Oxa 48.

Saturday began with Dr Monika Esser taking the crèche syndrome one step further. Ten infections a year may well be normal for a child attending a large day care, but there are specific circumstances when enough is enough and further investigation is necessary. SPUR – severe unusual Persistent Recurrent is a start but for more information see the websites.

Prof Prakash Jeena provided a look at the latest asthma guidelines and emphasised the use of MDI delivered SABA in acute asthma. Oxygen nebulisation must be reserved for hypoxic patients with life threatening asthma. IV magnesium sulphate is appropriate for use in life threatening asthma or in less severe asthma not responding to inhaled SABA.

(The guidelines were recently published in the SAMJ).

Dr Michele Zuckerman explained the genetics of coeliac disease highlighting the HLA DQ2 and DQ8 association and the very high negative predictive value of these markers. Tissue transglutaminase is the best non-invasive screening and diagnostic test but is dependent on a normal total IgA as it is itself an IGA antibody. So a normal total IgA is essential before interpreting the tissue transglutaminase. Autoimmune thyroiditis is a frequent comorbidity with coeliac disease. Anti-gladiadin antibody must not be used to screen for coeliac disease as it is too non-specific.

Prof Vic Davies discussed the role of probiotics in preventing NEC. A review of 20 RCTs involving 3816 patients less than 34 weeks gestation and less than 1500g showed a decrease risk of greater than Stage 2 NEC of 67% and a decreased mortality of 44%. Despite this review there is no clear recommendation because the research is strain specific. It is apparent that the positive effects of probiotics are restricted to specific strains linked to specific events. However, which strain is linked to which events is not clear. At present there is confounding evidence so no



PMG chair Dr Yatish Kara leads an informal discussion against a scenic backdrop during a break in proceedings

directive to use probiotics routinely is possible.

That concluded the formal academic side of the weekend. A VON discussion led by Dr Allan Puterman and Dr Andrew Halkas followed.

\*Social components of the weekend comprised a fantastic plated dinner on Friday evening and a dinner dance on Saturday night. Thank you again to the sponsors for inviting Lewis Gordon Pugh to our function, to present the after-dinner speech. It was truly a privilege to hear him speak about his achievements and his passion for protection of our marine resources. He is the first man to swim the length of the Thames, to swim across the polar ice cap, to swim the length of the Maldives and to swim the lake at Mount Everest.

Thank you to one and all for a fantastic weekend!

## SCENE AT DINNER



Enjoying the dinner entertainment were (from left). Casper Venter (CEO, Healthman), Dr Andrew Halkas, Dr Madni Noormohamed, and Mrs Noormohamed, Bhavna Jasmat (obscured) with husband and PMG chair, Dr Yatish Kara



cian who does not frequently see these ELBW neonates.

The suggestion therefore, is that we start a mentoring process. This means that neonatologists with experience in treating these babies will make themselves available to act as mentors. These mentors will be available telephonically and/or for hospital visits if possible. Any paediatrician faced with an NNICU problem and needs help or advice is able to give one of these mentors a call and the mentor will assist. The mentor will be paid by Discovery Health for his or her time and expertise at a fee still to be determined.

Dr Andrew Halkas and Dr Allan Puterman (above) then had a look at some VON data and highlighted that these children are perhaps best cared for in larger units where cases of this nature may



Dr Simon Strachan with his wife Veronica

## PMG/DISCOVERY NEONATAL CARE MENTORING PROPOSAL

Dr Errol Gottlich, Paediatric nephrologist and Discovery medical advisor, introduced this concept of mentoring for neonatal care in his presentation at the Arabella Advancing Paediatric weekend.

The care of Extremely Low Birth Weight (ELBW) neonate is becoming more common. Here he referred to children less than 1000g. Caring for these children requires skill in which we are trained as paediatricians, but also requires experience and time at the bedside. These children need constant re-evaluation, constant monitoring of fluid and electrolyte status and nothing can be left to chance. This can put huge pressure on a solo private paediatrician or on a paediatrician

who does not frequently see these ELBW neonates.

The VON data was clear, however, that better outcomes were not guaranteed at larger units. The large units in the UK and USA did have fewer ventilation days, less spend on radiology and pathology but longer lengths of stay. This concept of mentoring developed out of a

meeting between PMG exco and Discovery health towards the end of last year. The concept is in its neonatal stage and needs feeding and nurturing. The PMG exco will be establishing a national neonatal sub-committee to look at this initiative as well as many other neonatal specific issues. We encourage participation in this process and look forward to receiving input from or PMG members.

## PMG Update and AGM





# PMG EXCO 2013/2014

The Paediatrician Management Group executive committee\* for 2013/2014 was appointed by a vote by members during the PMG annual general meeting at Arabella on 20 April 2013. The Exco is:

Gerrit de Villiers	Cape Town	drgeritt@paediatrician.co.za
Andrew Halkas	Johannesburg	halkas@yebo.co.za
Yatish Kara	Durban	ykara@iafrica.com
Omolemo Kitchin	Johannesburg	omolemo.kitchin@telkomsa.net
Enrico Maraschin	Johannesburg	drrico@paediatrician.co.za
Allan Puterman	Cape Town	putall@global.co.za
Thesi Reddy	Durban	thesireddy@mweb.co.za
Simon Strachan	Johannesburg	simon@paediatrician.co.za

\*Members must feel free to contact any of the Exco whenever they require assistance.

NB: Our Managing Company is Healthman headed by:

- Casper Venter – [casper@healthman .co.za](mailto:casper@healthman.co.za)
- Ernst Ackerman – [provence @iafrica.com](mailto:provence@iafrica.com)



Healthman's Casper Venter updated members on practice management issues, particularly the ongoing debate on tariff guidelines, during the Arabella weekend

## IMPORTANT POINTERS FROM THE PMG DELIBERATIONS

### PMG/DISCOVERY GOVERNANCE PROJECT

It is important to note that the Paediatric Governance Project that is a PMG/Discovery health initiative will as of July this year be exclusive to PMG members. Non PMG members who are currently enjoying the benefit of participating in the governance project will be notified of this change and will be given an opportunity to join PMG. If the doctor chooses not to be a PMG member, then that doctor will not be able to participate in the governance project.

PMG Website – [www.paediatrician.co.za](http://www.paediatrician.co.za)

Or sincere thanks to ASPEN/GSK for their continued sponsorship of this website. We are constantly working to upgrade the functionality of the website and to keep the information current. You will see that a number of journals are available on the website. The strict copyright legislation makes it extremely difficult to have journals on the website that offer all the browsing functionality. We have Archives in Paediatrics available in this format thanks to a sponsorship from Astellas Pharma. The other journals are available in PDF format with no search capability.

### COMMUNICATION WITH MEMBERS

We are very aware that unsolicited email traffic can be annoying so we try to minimise the amount of email correspondence and advertising and reminders that we send to the members. It is however imperative that members pay attention to their emails because this is definitely the easiest way for the Exco to get the information out fast and accurately.

We will be using this online magazine Paediatric News as the monthly source of communication. In this magazine you will find a PMG section with news about what PMG is up to. There will be a section from SAPPF and between these two sections you will be kept up to date with happenings related to health economics/politics/funders and the business of Paediatrics. Lifestyle content and general news about the industry will be provided as well.

We are very keen on starting two new sections:

A question and answer section - Paed Q&A. Any question that you have regarding Paediat-

rics whether it be clinical or business related can be sent to either Dr Gerrit deVilliers ([drgeritt@paediatrician.co.za](mailto:drgeritt@paediatrician.co.za)) or to me ([simon@paediatrician.co.za](mailto:simon@paediatrician.co.za)) and we will ensure that the question is answered by a knowledgeable person in the field.

Paediatric journals. This section will highlight important publications and provide links to the articles. It would be ideal to create an editorial team of perhaps five colleagues who will be prepared to keep an eye on the journals and pass along relevant articles for publication. If you are interested in helping out with this small section, please send us an email.

We would like to keep this magazine hip and happening and any and all suggestions will be greatly appreciated.

### NEXT NATIONAL PMG MEETING FOR 2013

We are very happy to announce that Dr Reddy's has agreed to sponsor our next weekend. This will be on the weekend of 27-29 September 2013. The venue is still to be decided but we are preferentially sourcing a venue in Gauteng.

## STUDY EXAMINES TRENDS IN FIREARM INJURIES AMONG CHILDREN AND ADOLESCENTS

"Given recent firearm-related fatalities combined with declining gun research funding, it is important to monitor firearm injuries in youths. Injury death rates are available but provide an incomplete picture of these potentially preventable injuries," writes Angela Sauaia, M.D., Ph.D., of the University of Colorado School of Public Health, Denver and colleagues.

As reported in a Research Letter, the authors investigated the trends from 2000 to 2008 of both fatal and nonfatal firearm injuries in children and adolescents 4 to 17 years of age presenting to 2 Colorado urban trauma centers (in Denver and Aurora). The researchers compared firearm injuries with other injuries regarding patient characteristics (age, sex, race/ethnicity [white non-Latino vs. others], injury self-infliction, mortality, and intensive care requirement) and analyzed temporal trends regarding patient and injury characteristics as well as outcomes among fatal and nonfatal firearm injuries.

Overall, during this time period 6,920 youths

were injured. Firearms caused the injury in 129 of these youths (1.9 percent) (2.1 percent in 2000-2002; 1.9 percent in 2003-2005; 1.6 percent in 2006-2008). Firearm-wounded patients were more likely to be adolescent males, and their injuries were more often self-inflicted compared with youths with other injuries. Sixty-five patients (50.4 percent) with firearm injuries required intensive care vs. 1,311 patients (19.3 percent) with other trauma; 17 patients (13.2 percent) with firearm injuries died vs. 116 (1.7 percent) with other trauma. Firearm injury severity significantly increased over time.

"Firearms were an important mechanism of injury in the youth in this study. Compared with other serious injuries, firearm injuries were more severe, more often required intensive care, and claimed more lives, justifying focusing on pediatric firearm injuries as a prevention priority," the authors write. "More recent data from other areas with detail on the circumstances of the firearm injury are needed."

Source: [www.medicalnewstoday.com](http://www.medicalnewstoday.com)

## FEVER WITHOUT SOURCE IN INFANTS AND YOUNG CHILDREN: DILEMMA IN DIAGNOSIS AND MANAGEMENT

Elhassanien AF et al. – There is controversy surrounding the management of young children who have a fever without a source (FWS). Several strategies have been designed with the purpose of managing children with FWS. The guideline followed in pediatric emergency unit seemed to be appropriate in following up with these children using simple laboratory tests. The most frequent SBI in this sample was urinary tract infection.

### METHODS

- To assess the applicability of a standardized guideline for children up to 36 months of age with FWS.
- Pediatric emergency unit, Al-Adan Hospital, Kuwait City, Kuwait, from May 2011 to October 2011.
- Prospective, cross-sectional study.
- The study involved children with FWS up to 36 months of age.
- The guideline classifies the risk of serious bacterial infection (SBI) according to the age of the child, the presence or absence of toxemia, clinical presentation, and laboratory screening tests.

### RESULTS

- A total of 481 children were included in the present study, but only 385 cases completed the study; 3.9% of patients had toxemia at the initial evaluation.
- The authors found 26 children with SBI (6.8%); 12 patients with SBI did not present with toxemia.
- In all, 40.4% of studied newborns were diagnosed as having a urinary tract infection, and 42.7% of patients as self-limited probable viral etiology.
- Of the 109 young infants without toxemia, 53.2% were classified as being at high risk of SBI.
- Of the 163 toddlers without toxemia, 72.4% were treated with antibiotics; 48.4% of patients received therapeutic treatment and 25.8% received empirical treatment.

Source: <http://www.mdlinx.com>

## MORE SEVERE CONCUSSION SYMPTOMS LEAD TO LONGER RECOVERY TIME

Most children who suffer from sports-related concussions recover within a few days. However, in a small number of children, symptoms can last for a month or more. Although there have been numerous theories as to what might predict a longer recovery time, there is no definitive answer as to why it takes some children longer to recover. In a new study scheduled for publication in *The Journal of Pediatrics*, researchers attempted to identify risk factors that might predispose some children with concussions to longer recovery times.

Dr. William P. Meehan, III and colleagues from Boston Children's Hospital and the University of Pittsburgh Medical Center analyzed data from 182 patients who were seen at a sports concussion clinic within 3 weeks of injury. Patients completed the Post-Concussion Symptom Scale (PCSS), which contains 22 different symptoms that they ranked from 0-6 (0 = not experiencing a given symptom; 6 = describing the symptom as "severe"). Patients were separated into 2 groups: those who were symptom-free within 28 days and those who had symptoms for longer than 28 days. After analyzing data for numerous variables, including total score of the PCSS at initial visit, age, and amnesia symptoms, only the total score on the PCSS was independently associated with symptoms lasting longer than 28 days; the higher the score, the greater chance of a prolonged recovery time.

Although it is important for patients who suffer from prolonged symptoms of concussion to receive medical management, along with academic and occupational accommodations, most patients recover without needing these. Identifying risk factors for potentially prolonged recoveries will allow clinicians to coordinate the best treatment for patients. According to Dr. Meehan, "Parents, physicians, and caregivers of athletes who suffer from a high-degree of symptoms after a sports-related concussion should start preparing for the possibility of a prolonged recovery." Although some studies have shown longer recovery times in younger patients and patients who suffered from amnesia, results from this study do not suggest that age or amnesia are risk factors for prolonged recovery time. Instead, efforts to develop clinical tools for predicting which athletes will suffer prolonged recoveries after concussion should focus on initial symptom score.

Source: <http://www.medicalnewstoday.com>

**S3 TOPRAZ - a jewel in the control of chronic atopic asthma in adults and children >2 years**



**Montelukast (Leukotriene modifier: Leukotriene Receptor Antagonist)**

Indicated for the prophylaxis and treatment of chronic atopic asthma in adults and children > 2 years of age.

Montelukast is included in both South African and International Guidelines for use in the managements of chronic asthma.<sup>1,2,3</sup>

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Respiratory



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## HEALTHIEST KIDS EAT SAME FOOD AS PARENTS



Young children who eat the same meals as their parents are far more likely to have healthier diets than those who eat different foods, according to research.

Children who rarely or never eat the same food as their parents had the poorest diets, compared with children who do.

### GOOD EATING HABITS

A University of Edinburgh researcher looked at different aspects of family meals of more than 2000 five year olds, drawing upon data from the Growing Up In Scotland study.

Whether children ate the same food as their parents or not had the biggest impact on children's diets. This was true regardless of the families' backgrounds.

In light of the new findings, the paper calls for more attention to be paid towards helping parents establish good eating habits in their children's early years.

Shared family meal time not significant

Other meal habits had a much smaller impact on diet. Among these, not eating a main meal during the day or at regular times, frequent snacking between meals, eating in the living room or bedroom, and an unpleasant

atmosphere during mealtimes were all weakly associated with poorer diets. Whether children ate with other family members was not significantly linked to children's dietary quality.

The study also found that firstborn children had healthier diets than second or third born.

### DIFFICULT PART OF THE DAY

While the research found benefits in family meals it also confirmed that mealtimes could be a difficult part of the day.

A quarter said family meals were never or only occasionally enjoyable for everyone. Nearly one in seven (14%) families found that mealtimes were rushed, with a fifth reporting that they never or rarely had the chance to talk during meals.

### SIMPLE GUIDELINES

The paper recommends that government guidelines should be kept simple. It also says that some of the current targets, such as providing up to two grams of salt to children under three, expect parents to monitor nutritional targets in an unrealistic and impractical way.

Source: <http://www.ed.ac.uk>



## CHILDHOOD MENINGITIS ASSOCIATED WITH LOWER LEVELS OF EDUCATIONAL ACHIEVEMENT, FINANCIAL SELF-SUFFICIENCY IN ADULTHOOD

In a study that included nearly 3,000 adults from Denmark, a diagnosis of meningococcal, pneumococcal, or Haemophilus influenzae meningitis in childhood was associated with lower educational achievement and economic self-sufficiency in adult life, according to a study in the April 24 issue of JAMA.

Bacterial meningitis may lead to brain damage due to several factors, and survivors of childhood bacterial meningitis are at particular risk of hearing loss, seizure disorders, motor deficits, and cognitive impairment. Learning disabilities are well documented as a result of the disease. "To our knowledge, no previous study has examined functioning in adult life among persons diagnosed as having bacterial meningitis in childhood," the authors write.

Casper Roed, M.D., of Copenhagen University Hospital, Copenhagen, Denmark, and colleagues conducted a study to estimate educational achievement and economic self-sufficiency among children surviving bacterial meningitis compared with the general population. The nationwide population-based cohort study used national registries of Danish-born children diagnosed as having meningococcal, pneumococcal, or H influenzae meningitis in the period 1977-2007 (n=2,784 patients). Comparison cohorts from the same population individually matched on age and sex were identified, as were siblings of all study participants. The end

of the study period was 2010. The primary measured outcomes were cumulative incidences of completed vocational education, high school education, higher education, time to first full year of economic self-sufficiency, and receipt of disability pension and differences in these outcomes at age 35 years among meningitis patients, comparison cohorts, and siblings.

The study included persons who had a history of childhood meningococcal (n=1,338), pneumococcal (n=455), and H influenzae (n=991) meningitis. Among meningococcal meningitis patients, an estimated 11.0 percent fewer (41.5 percent vs. 52.5 percent) had completed high school and 7.9 percent fewer (29.3 percent vs. 37.2 percent) had obtained a higher education by age 35 compared with members of the population comparison cohort. For pneumococcal meningitis patients, by age 35, an estimated 10.2 percent fewer (42.6 percent vs. 52.8 percent) and 8.9 percent fewer (28.1 percent vs. 37.0 percent) had completed high school and higher education compared with members of the population comparison cohort.

Among H influenzae meningitis patients, 5.5 percent fewer (47.7 percent vs. 53.2 percent) had completed high school and 6.5 percent fewer (33.5 percent vs. 40.0 percent) had completed higher education by age 35 years compared with members of the population comparison cohort.

The authors also found that at end of follow-up, an estimated 3.8 percent, 10.6 percent, and 4.3 percent fewer meningococcal, pneumococcal, and H influenzae meningitis patients, respectively, had been economically self-sufficient compared with the individuals from the comparison cohort, and 1.5 percent, 8.7 percent, and 3.7 percent, respectively, more patients received disability pension.

"Siblings of meningococcal meningitis patients also had lower educational achievements, while educational achievements of siblings of pneumococcal and H influenzae meningitis patients did not differ substantially from those in the general population," the researchers write.

These findings suggest that the association with lower educational achievement and economic self-sufficiency in adult life may apply particularly to pneumococcal and H influenzae meningitis, whereas for meningococcal meningitis the lower educational achievement may be family related.

"Our study suggests that children diagnosed as having pneumococcal or H influenzae meningitis may benefit from follow-up into adulthood to identify those who could potentially benefit from psychosocial support."

Source: [www.medicalnewstoday.com](http://www.medicalnewstoday.com)

## NEW METHOD MAKES IT EASIER TO INVESTIGATE DEVASTATING CHILDHOOD DISEASES

Induced pluripotent stem cells (iPSCs) from the skin of patients with Dravet syndrome (DS) show Dravet-like functional impairment when they are converted into neurons, finds research in BioMed Central's open access journal Molecular Brain. This method provides a non-invasive way to investigate diseases which affect the nervous system of humans.

Research into genetic diseases like DS is hampered by its rareness. It affects 1 in 30,000 children and is first noticed within the first year or two of life. Seizures are hard to control and as the child develops other neurological problems emerge meaning that most will require help and support throughout life.

70-80% of people with DS have a mutation in their SCN1A gene which disrupts normal function of voltage-gated sodium channels in the brain. This mutation is normally not inherited from either parent but is unique to the affected child. Research models of DS usually involve mice which have been genetically altered to so that either this channel is mutated or deleted. But differences between the brains of humans and mice means that mice are not necessarily the best model for this rare disease.

Work describing how, under certain experimental conditions, tissue cells can be reverted to stem cells was honoured in the 2012 Nobel prize for Physiology or Medicine. In this research, a team from Japan developed (iPSCs) from skin cells

taken from an adult with DS who had a mutation in SCN1A. These cells were then differentiated into neurons allowing researchers to look at the effect of DS directly in human cells.

Explaining their results Prof Shinichi Hirose, from Fukuoka University, said, "From research with mice we believed that SCN1A mutations affect GABAergic neurons in the forebrain from signalling properly. From the human neurons we also found that GABAergic neurons were affected by DS, especially during intense stimulation. These patient-derived cells provide an unparalleled insight into the mechanism behind DS and a unique platform for drug development."

Source: <http://www.medicalnewstoday.com>

## PRENATAL VALPROATE EXPOSURE AND RISK OF AUTISM SPECTRUM DISORDERS AND CHILDHOOD AUTISM

Christensen J et al. – This study aimed to determine whether prenatal exposure to valproate is associated with an increased risk of autism in offspring. Maternal use of valproate during pregnancy was associated with a significantly increased risk of autism spectrum disorder and childhood autism in the offspring, even after adjusting for maternal epilepsy. For women of childbearing potential who use antiepileptic medications, these findings must be balanced against the treatment benefits for women who require valproate for epilepsy control.

### METHODS

- A population-based study of all children born alive in Denmark from 1996 to 2006.
- National registers were used to identify children exposed to valproate during pregnancy and diagnosed with autism spectrum disorders (childhood autism [autistic disorder], Asperger syndrome, atypical autism, and other or unspecified pervasive developmental disorders).
- Authors analyzed the risks associated with all autism spectrum disorders as well as childhood autism.
- Data were analyzed by Cox regression adjusting for potential confounders (maternal age at conception, paternal age at conception, parental psychiatric history, gestational

age, birth weight, sex, congenital malformations, and parity).

- Children were followed up from birth until the day of autism spectrum disorder diagnosis, death, emigration, or December 31, 2010, whichever came first.
- Absolute risk (cumulative incidence) and the hazard ratio (HR) of autism spectrum disorder and childhood autism in children after exposure to valproate in pregnancy.

### RESULTS

- Of 655615 children born from 1996 through 2006, 5437 were identified with autism spectrum disorder, including 2067 with childhood autism.
- The mean age of the children at end of follow-up was 8.84 years (range, 4–14; median, 8.85).
- The estimated absolute risk after 14 years of follow-up was 1.53% (95% CI, 1.47%–1.58%) for autism spectrum disorder and 0.48% (95% CI, 0.46%–0.51%) for childhood autism.
- Overall, the 508 children exposed to valproate had an absolute risk of 4.42% (95% CI, 2.59%–7.46%) for autism spectrum disorder (adjusted HR, 2.9 [95% CI, 1.7–4.9])

and an absolute risk of 2.50% (95% CI, 1.30%–4.81%) for childhood autism (adjusted HR, 5.2 [95% CI, 2.7–10.0]).

- When restricting the cohort to the 6584 children born to women with epilepsy, the absolute risk of autism spectrum disorder among 432 children exposed to valproate was 4.15% (95% CI, 2.20%–7.81%) (adjusted HR, 1.7 [95% CI, 0.9–3.2]), and the absolute risk of childhood autism was 2.95% (95% CI, 1.42%–6.11%) (adjusted HR, 2.9 [95% CI, 1.4–6.0]) vs 2.44% (95% CI, 1.88%–3.16%) for autism spectrum disorder and 1.02% (95% CI, 0.70%–1.49%) for childhood autism among 6152 children not exposed to valproate.

Source: <http://www.mdlinx.com>



## MORE SEVERE CONCUSSION SYMPTOMS LEAD TO LONGER RECOVERY TIME

Cincinnati, OH, April 25, 2013 -- Most children who suffer from sports-related concussions recover within a few days. However, in a small number of children, symptoms can last for a month or more. Although there have been numerous theories as to what might predict a longer recovery time, there is no definitive answer as to why it takes some children longer to recover. In a new study scheduled for publication in *The Journal of Pediatrics*, researchers attempted to identify risk factors that might predispose some children with concussions to longer recovery times.

Dr. William P. Meehan, III and colleagues from Boston Children's Hospital and the University of Pittsburgh Medical Center analyzed data from 182

patients who were seen at a sports concussion clinic within 3 weeks of injury. Patients completed the Post-Concussion Symptom Scale (PCSS), which contains 22 different symptoms that they ranked from 0-6 (0 = not experiencing a given symptom; 6 = describing the symptom as "severe"). Patients were separated into 2 groups: those who were symptom-free within 28 days and those who had symptoms for longer than 28 days. After analyzing data for numerous variables, including total score of the PCSS at initial visit, age, and amnesia symptoms, only the total score on the PCSS was independently associated with symptoms lasting longer than 28 days; the higher the score, the greater chance of a prolonged recovery time.

Although it is important for patients who suffer from prolonged symptoms of concussion to receive medical management, along with academic and occupational accommodations, most patients recover without needing these. Identifying risk factors for potentially prolonged recoveries will allow clinicians to coordinate the best treatment for patients. According to Dr. Meehan, "Parents, physicians, and caregivers of athletes who suffer from a high-degree of symptoms after a sports-related concussion should start preparing for the possibility of a prolonged recovery." Although some studies have shown longer recovery times in younger patients and patients who suffered from amnesia, results from this study do not suggest that age or amnesia are risk factors for prolonged recovery time. Instead, efforts to develop clinical tools for predicting which athletes will suffer prolonged recoveries after concussion should focus on initial symptom score.

Source: <http://www.jpeds.com>



## DISCOVERY OF MUTATION DRIVING PEDIATRIC BRAIN TUMORS

A type of low-grade but sometimes lethal brain tumor in children has been found in many cases to contain an unusual mutation that may help to classify, diagnose and guide the treatment of the tumors, report scientists at Dana-Farber Cancer Institute.

The researchers led a study of pediatric low-grade gliomas, samples of which were collected through an international consortium organized by brain tumor specialists at Dana-Farber/Children's Hospital Cancer Center. Their findings were published online by the Proceedings of the National Academy of Sciences (PNAS) the week of April 29.

Low-grade gliomas are the most common type of pediatric brain tumors, diagnosed in about 1,000 young patients annually in the United States. There are about 30 distinct types of these tumors, which arise from specialized cells called glia in the brain. Low-grade gliomas are generally slow-growing, said Keith Ligon, MD, PhD, a senior author of the study, but they behave unpredictably and can be life-threatening.

The investigators focused on diffuse low-grade gliomas, so-called because they lack a tumor mass but spread throughout the brain. As a result, diffuse gliomas often recur after surgery and are more likely to evolve into lethal glioblastomas than are non-diffuse low-grade tumors. "Many of these patients do well, but it's hard to generalize as the tumors are difficult to diagnose and study because without better tools pathologists can't name them consistently," explained Ligon, who in addition to being a researcher is also a neuropathologist. The research was undertaken in hopes of identifying a common genetic alteration that could be used to better define and design treatments for them.

The researchers analyzed DNA from 45 tissue samples collected from seven institutions in collaboration with Rameen Beroukhim, MD, PhD, a Dana-Farber genome biologist and co-senior author of the study. They looked for mutations caused by extra or missing copies of DNA code in the tumor genomes.

One alteration stood out: a gene called MYBL1,

a transcription factor important for controlling other genes, was rearranged and missing a part of its genetic message in nearly 30 percent of the diffuse tumors categorized as grade 2 in terms of aggressiveness. The scientists went on to show that the mutated version of MYBL1 can cause tumors in mice. Previously MYBL1 was not known to cause cancer, but a closely related gene, MYB, is one of the oldest "proto-oncogenes" - a normal gene that can become a cancer-causing gene.

"The creation of these truncated genes, reminiscent in structure of the viral oncogene, is a potential driver for this type of tumor," said Lori Ramkissoon, PhD, co-first author along with Peleg Horowitz, MD, PhD, a neurosurgery resident, both of Dana-Farber. "It gives us something to follow up on and investigate the function of this gene. It may lead to a specific test for diagnosing these tumors, and we will also try to determine whether patients who have this mutation do better or worse than those lacking the mutation."

Source: <http://www.medicalnewstoday.com>

# SAMED EXPRESSES RESERVATIONS ABOUT CENTRAL PROCUREMENT FOR MEDICAL TECHNOLOGY

**THE SOUTH AFRICAN MEDICAL DEVICE ASSOCIATION HAS SOME RESERVATIONS ABOUT THE DEPARTMENT OF HEALTH'S DECISION TO TAKE OVER THE PROCUREMENT OF MEDICALLY RELATED ITEMS FROM NATIONAL TREASURY OVER THE NEXT FEW YEARS.**

The National Department of Health recently announced that it will be taking over the procurement of medically related items over the next few years.

"We recognise that the proposal of a 'central procurement agency' with National Health taking over the contract management relating to medical technology is a first step on a long road to full implementation of the healthcare vision and a means to curb corruption," says Tanya Vogt, COO of SAMED.

However, SAMED does not believe that central procurement will work for all types of medical technology.

Vogt says that the first step to providing access to affordable, appropriate and high quality medical technology is dependent on the establishment of an efficient and effective regulatory framework. This legislation should identify minimum standards (which are aligned to international standards) to be implemented by medical technology suppliers and healthcare providers.

Medical technology raises the following challenges for a tendering system:

- Medical technology undergoes rapid cycles of improvement (every 6- 24 months) and is adjusted to meet different patient and doctor needs.
- Medical devices often remain implanted in a patient or in use at a hospital for many years. Much of the cost and economic value of medical devices is not only in the purchase price but also the quality, service, technical support and training and education providers by manufacturers/suppliers.
- Medical equipment maintenance is critical – a supplier may offer a good price but not provide any maintenance services, or spare parts may be difficult to come by.

- To meet different physician and patient needs, medical device tendering contracts should not be exclusive, but should allow for participation of multiple models and types.

"It will be of significant value for the Department of Health to recognise the complexity of medical technology by taking an approach tailored to individual models of devices rather than trying to group products into broad categories," continues Vogt.

SAMED offers the following suggestions to improve the system of national tendering for devices.

- SA is an important market for medical device companies and therefore competitors will make attractive offers for national tenders. The best way to ensure such competition is to make contract terms binding and clear in advance.
- An efficient and cost effective purchasing and procurement system is critical to the success and sustainability of the reformed healthcare structure. This requires one national database of all medical items which is continuously updated with stock levels at every healthcare facility. Procurement without this system can cause extreme shortage or over supply. Furthermore, competitive tendering should recognise the value of innovation in medical technology to patients, clinicians and the healthcare system and should reward features that bring new capabilities and improved options to the clinical pathway. An effective system has the correct medical equipment, consumables and implants at the critical 'point of care'.

"SAMED would like to actively engage and work with the Department of Health to achieve a significant improvement in the procurement processes for medical technology, to the benefit of all South Africans," concludes Vogt.



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# Summary of Health News

## MARCH HIGHLIGHTS

**Competition Commission:** Although there are hopes that the Competition Commission's (CC) inquiry into pricing and possible collusion in the healthcare market (commencing on April, 1) are supposed to identify and root out anti-competitive behaviour, critics in the mass and social media think the inquiry has more to do with implementing NHI than addressing anti-competitive behaviour in the industry. A research note released by Econex last year points out that under the NHI system the government "will have to buy services from the private healthcare sector, and it wants to ensure that these rates are not inflated". (HealthMan summary: econexsummary). Some critics advise Health Minister Motsoaledi to start by putting his house in order and first clean up the public healthcare sector.

According to the latest audit of public healthcare facilities - in preparation of the NHI - only 53% met patient care stan-

dards, 40% had sound infrastructure and only 30% offered good clinical services.

"Although Motsoaledi has stepped up to the plate and admitted that public healthcare is not far short of a nightmare, his juniors do not seem able to make that same leap," - The Star 18 March

The question the CC will be faced with is whether there is active collusion in the healthcare industry or whether, due to skills shortages, medical professionals are able to charge what they choose as there is naturally limited competition. A return to a recommended price list would greatly assist consumers to make informed decisions about the price of their healthcare.

A research report conducted last year by analysts at the CC suggested that an inquiry should look at how consumers choose medical schemes. It also recommended that entry into the healthcare

market be made easier and that ways be found to increase transparency with regard to the choice of product quality and price.

**Medical aid corruption:** In its editorial comment on 19 March, The Cape Times addresses the matter of medical aid corruption: "This kind of fraud is particularly easy - and shameful - because patients are by definition in a vulnerable situation, dependent on their doctors and hospitals." Patients tend to trust their doctors and do not easily suspect them of fraud. The victims are the 8,5-m members of medical schemes, as schemes battling to meet costs cut back on the benefits they offer their members or increase medical aid contributions, putting medical aid out of the reach of many households and reducing the schemes' long-term ability to spread risk. (Also read the attachment: mschemes13)

## National Health Insurance (NHI) & Public Health

### CMS IS WITNESS IN HEALTHCARE PRICING INQUIRY

Monwabisi Gantsho, the Council for Medical Schemes' (CMS) chief executive and registrar, said the council would become an integral part of price determination as a result of its collaboration

with the inquiry by the CC. The CMS proposed in the Medical Schemes Amendment Bill that it should be given power to collect critical information from hospitals that currently fall outside of its regulation capacity.

- The CMS tabled its budget for 2013/14, in which it sought to increase its funding to R110,1-m from R98,4-m in the 2012/13 financial year. Its total income excluding levies was estimated at R6,9-m and, therefore, R103,2-m would have to come from medical scheme levies (an increase of 9,85% could be expected). Most of the budget would fund the move to bigger offices and an increased staff complement.

Source: Business Report



### DOUBTS IN SOWETO OVER NHI PLANS



Soweto's private sector general practitioners (GPs) are broadly in favour of the NHI plan, but question the states capacity to implement it, according to a survey by Murire & Company. About 70% of the 40 doctors polled by the consulting firm said the fact that the government had failed to manage public hospitals and clinics effectively meant it would find it difficult to successfully implement NHI.

Source: Business Day



## HEALTHCARE INQUIRY:

# SECTOR CLEARED FOR SURGERY; 'COLLUSION' TO BE PROBED; PRICES IN THE PRIVATE SECTOR

According to the CC's divisional manager, Clint Oellermann, the commission's inquiry into pricing and possible collusion in the healthcare market will start on April 1. The inquiry follows complaints to the CC about many practices and will probe whether there were agreements to charge set prices for procedures or consultations. Pharmaceutical companies would not form part of the inquiry. Recommendations for new policy or regulations will be made to the Minister of Economic Development.

Although there are hopes that the CC's inquiry would identify and root out anti-competitive behaviour, Critics in the mass and social media think the inquiry has more to do with implementing NHI than addressing anti-competitive behaviour in the industry. Some advise that Health Minister Motsoaledi should start by putting his house in order and first clean up the public healthcare sector.

Meanwhile the proclamation of the Competition Amendment Act has been branded as a move to launch a "draconian witch hunt" into price setting by attorneys representing clients in the private healthcare industry. The Act gives the CC the power to investigate the general state of competition in industries. The investigator may summons industry players to question them under oath. Failure to comply may lead to a fine of R2 000 or imprisonment of up to six months. Companies and individuals are expected to cover their own legal costs.

Lawyers claim Min Motsoaledi used his executive powers to push the Act through so that prices charged by private doctors and private hospitals can be decreased significantly in time for the implementation of the NHI. Given the general poor state of public health facilities in SA, the NHI would be compelled to contract private healthcare providers to provide services if it is to operate efficiently. Prior to the proclamation, the CC only had the power to conduct inquiries into specific companies in an industry and mostly only after a formal complaint. The

CC is now able to conduct an inquiry if it has reason to believe that any feature of a market prevents, distorts or restricts competition.

\*Reaction: Paul Coetser, director of Werksmans Attorneys' described the proclamation of the Amendment Act as "a great surprise" because the Act had been in limbo for the past three and a half years.

Trudi Makhaya, the CC's advocacy and stakeholder relations manager, said the body had no control over the timing of the proclamation of

the Act. However, an urgent investigation into the private healthcare sector was needed to establish "why the free-market system has not worked in this sector, why competition has not managed to drive down prices and what alternative model may work better".

SA Dental Association's chairperson, Maretha Smit, said they would "no doubt" threaten the commission with legal action if dentists

perceived the investigation to be unfair, unscientific and not transparent.

The Private Practitioners' Forum chairperson, Chris Archer, said an investigation would give doctors the opportunity to show that what their charges were not excessive and medical aid rates did not meet their costs.

Roly Buys, a Mediclinic executive, said his company had "nothing to hide" because its financial information was "public anyway" as it was listed on the JSE.

According to the social justice organisation Section27, the new legislation is essential.

Senior researcher Sha'ista Goga said the Act provided a framework and structure for a sorely needed investigation into price setting in the industry.

Source: Mail & Guardian; SAPA; Business Report

## PRIVATE HEALTHCARE IS 'WASTEFUL, COSTLY'

The private healthcare sector is wasteful and its excessive pricing could lead to further shrinking of benefits if costs continued to escalate, said Lord Nigel Crisp, member of the UK House of Lords and board member of SA Department of Health's (DoH) Academy. The system suffers from over-treatment, excessive pricing and it is very hospital-focused. The SA system mimicked that of the US, which was characterised by large use of the private sector and private health insurance. Over-treatment cost the US healthcare system between \$158-bn and \$226-bn in 2011. SA spends a higher proportion of gross domestic product on healthcare than most of its Bric counterparts Brazil, Russia, India and China, however, scores worse on indicators such as its maternal mortality rate and tuberculosis. SA should not confuse healthcare with social care, especially among the elderly, as this was one of the factors that pushed up healthcare costs in the UK.

Source: Business Report



## AUDIT: HEALTH CENTRES IN A SHAMBLES; MATSOSO DEFENDS RESULTS; MPS SET DEADLINE FOR NHI FUNDING PLAN

According to the latest audit of public healthcare facilities - in preparation of the NHI - only 53% met patient care standards, 40 % had sound infrastructure and only 30% offered good clinical services. Only 43% of management was adequate: Of the 3 800 health facilities, 504 (13%) had no domestic waste removal, 36 (3,5 %) had no medical waste removal, at least 174 had no hazardous waste removal, 56 clinics had no water and 36 no electricity. Gauteng scored 69% for quality, KZN 58%, the Free State 57% and Western Cape 57%. For infrastructure, Gauteng scored 70% and the Western Cape ranked fifth at 54%.

- Reaction: The DA has accused the DoH of spinning the findings of the audit and said it was politically motivated. Health director-general, Precious Matsoso, did not elaborate on the methodology used to calculate the provincial rankings in her presentation to MPs, but deputy director Jeanette Hunter

conceded that the scoring system might result in anomalies. In the Western Cape, 21 facilities, managed by the City of Cape Town, were not audited as the city refused on the grounds that they were compliant.

- Meanwhile Parliament's two finance committees have set the Treasury a deadline of six months (after the report has been adopted by the National Assembly and the National Council of Provinces) to submit their reports on a funding model for the proposed NHI scheme. The model must ensure that low-income taxpayers are not burdened by the scheme. How the NHI will be funded has been a rather elusive issue.

Source: *The Cape Times; Business Day*

Visit <http://www.doh.gov.za/docs/reports/2013/Healthcare.pdf> for a copy of the report.



## HEALTH REGULATIONS:

## MOTSOLEDI DEFENDS STRICT REGULATIONS

New smoking regulations would, inter alia, restrict the smoking of tobacco outside of buildings and the distances from other people they may smoke in public places. Although the regulations on smoking have elicited criticism, Min Motsoaledi said the government would not stop regulations while people were still choosing to smoke tobacco. The Free Market Foundation called the Tobacco Products Control Act "unconstitutional, impractical and ill-considered".

Meanwhile Motsoaledi's proposals of restricting the sale of liquor to certain days have also been met with contention from businesses and society in general.

The DoH has also expressed intentions to halve salt composition in different food goods, in a bid to improve the state of health in the country. The Consumer Goods Council of SA had written to the Health Minister about alternative approaches to ensure a reduction in salt content, but Motsoaledi reacted that measures were being taken around the world regarding health and diet to ease "an explosion of health problems".

Source: *Business Day; SAPA*

## News On HIV/AIDS, TB, Malaria & Communicable Diseases

## REVACCINATION PLAN ON CARDS FOR TEENAGERS

Scientists in SA are considering revaccinating teenagers with the Bacille Calmette Guérin (BCG) shot to see if they can get more mileage out of the jab. The shot is given to 100-million babies around the world each year, and while it initially provides them with fairly good protection against tuberculosis (TB) its effects rapidly wane over time which means it has limited effect on the spread of the disease.

Prof Willem Hanekom from the University of Cape Town said Worcester would be the ideal place



for a trial of teenage reimmunisation with BCG, as about 40% of the teenagers in the town were infected with TB. By the time they were 18, 65% -70% of them would be infected.

Source: *Business Day*

## COST OF HIV TREATMENT TO ROCKET

Though Gauteng's cost of treating people with HIV and preventing new infections are expected to double; funding from the US government is expected to halve, according to the CEO of the SA AIDS Council, Fareed Abdullah. Money from a US presidential fund for SA's HIV programmes will drop from 2011's \$500-m to \$250-m a year by 2017. Donations have been cut in the wake of the global financial crises. In the next four years, the cost of helping HIV patients in Gauteng will reach R6-bn a year.

Source: *The Times*



## HIV-PREVENTION DRUG'S HYPE FALLS FLAT; HIV ONE PILL A DAY; 28% OF SCHOOLGIRLS ARE HIV-POSITIVE

A study conducted mostly in SA on the pill-a-day HIV-prevention tool has been dealt a huge blow as it was found that most women did not adhere and take the single ARV drug daily. The VOICE (Vaginal and Oral Interventions to Control the Epidemic) trial tested whether ARV pills tenofovir, Truvada (a combination of tenofovir and emtricitabine) or a tenofovir gel (a vaginal microbicide) are safe and effective in preventing the sexual transmission of HIV. Dr Jeanne Mrazek of the University of Washington in Seattle confirmed that results showed that daily use of the pills or microbicide was neither effective nor acceptable to the more than 5 000 women. VOICE provided a clear answer - daily use of the product was not the right approach for African women. The next prevention hope now lies with two ongoing trials - ASPIRE and The Ring Study.

- Meanwhile Health Minister Motsoaledi has announced that from April 1, HIV-positive people (pregnant women included) on ARTs will be able to take one pill a day, instead of three pills twice a day. The single pill is thanks to a new government tender for a generic that combines the three first-line ARVs, tenofovir, emtricitabine (FTC) and efavirenz, into one pill. New patients and pregnant women were being prioritised for the fixed-dose combination (FDC) pill treatment. For those who were already on ART it would be left up to their doctors to decide whether to change them over.
- Min Motsoaledi confirmed a report that at least 28% of schoolgirls are HIV-positive while only 4% of young boys are infected with the virus in the country. He said 94 000



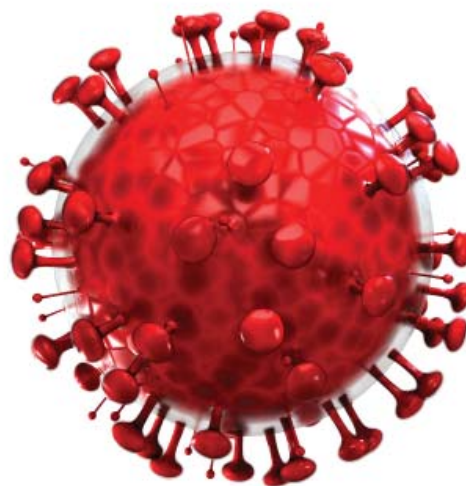
schoolgirls fell pregnant across the country in 2011. About 77 000 girls had abortions at public facilities.

*Source: Sowetan; Health-e News Service*

## HIV-INFECTED INFANT CURED; HIV 'CURE' IN INFANCY; VIRAL LOADS REMAIN UNDETECTABLE IN ABSENCE OF ARVS

The US reported from Mississippi that for the first time an infant born with HIV was cured by giving her a cocktail of drugs shortly after birth. The baby took a regimen of AIDS drugs and at 18 months the mother took the child off the medication. With no signs of the virus for 10 months, the infant was deemed "functionally cured," researchers said.

- AIDS experts have cautioned against the hype the cure caused and stressed that it might have been a freak result. Oxford University AIDS researcher John Frater said it is important to concentrate on preventing children from getting HIV through screening pregnant women and putting those with HIV on ARV treatment.
- Meanwhile a study from France has found 14 adult patients who also started on ARVs soon after infection, subsequently stopped it, and have not had to re-start because they have largely - and in 8 cases completely - maintained undetectable viral loads for at



least four years after stopping therapy. Researchers suggest that such cases are more common because, once having started ART, few people stop. They could subsequently become so-called "post-treatment controllers". This is a stark contrast to findings from studies between 1996 and 2000, which looked at HIV control in people who had received treatment for 12 to 18 months. The French patients had been on treatment for an average of three years before stopping, and all started treatment within ten weeks of infection, compared to within six months in previous studies.

- Researchers continue studying a drug by Merck & Co for a rare type of cancer after it showed early signs of being able to clear the hidden deposits of HIV, and Gilead is testing a cancer drug called Istodax.

*Source: Bloomberg; SAPA; AIDSmap via Health-e News Service*

# RECORD GENE HAUL POINTS TO BETTER CANCER SCREENING



According to Doug Easton, a cancer researcher of the University of Cambridge, a batch of new genetic discoveries meant medical experts would be able to develop new cancer screening programmes. The new research has nearly doubled the number of genetic variations implicated in breast, prostate and ovarian cancer, offering fresh avenues for screening at-risk patients and, potentially, developing better drugs. It follows an international project to analyse the DNA of more than 200 000 people - half of them with cancer and half from the general population - to find alterations that are more common in individuals with the disease cancer. A few of the variations were common to more than one cancer type, suggesting there may be common mechanisms of action that could be targeted by new drugs. The new research was published in *Nature Genetics*, *Nature Communications*, *PLOS Genetics*, the *American Journal of Human Genetics* and *Human Molecular Genetics*.

Source: Reuters

## Doctors, Nurses, Hospitals & Training

CONFLICTING REPORTS:

### GAUTENG HEALTHCARE SYSTEM IN ICU; GAUTENG HEALTH TURNAROUND WORKING

Social justice action group, Section27, released a report painting a grim picture of the state of Gauteng's 33 hospitals. Section27 director, Mark Heywood, described the system as a "nest of snakes where nobody can hold anybody accountable". The report lists several health system failures, among others:

- Children are contracting diseases they should have been immunised against;
- Tertiary hospitals are increasingly unable to offer specialised care due to a lack of medicines they require;
- Broken equipment preventing medical interventions such as anaesthetics, radiology and oncology;
- A lack of wheelchairs, stretchers and beds;

- Power outages at Chris Hani Baragwanath forcing surgeons to operate using headlights and cellphones;
- At Charlotte Maxeke the delays in appointing critical staff caused the cancellation of between 20% and 25% of operations due to a shortage of anaesthetists; and
- Newborn babies died or were left disabled at Chris Hani Baragwanath in an understaffed maternity unit.

Heywood said nobody was ever held accountable and heads of department and MECs were shuffled in and out of their positions without any questions asked or consequences.

Sources: SAPA; The Citizen; Health-e News Service

### WESTERN CAPE: MOBILE CLINIC FIRST FOR AFRICA



A solar-powered clinic on wheels (targeted at rural areas) has been unveiled in Cape Town and billed as Africa's first solar-powered mobile healthcare centre. The 7m truck includes a fully-equipped eye and blood clinic and a dental surgery. Patients will be screened for conditions such as diabetes, HIV, malaria, high blood pressure, tooth decay and cataracts. A mother-and-child clinic equipped with 4D ultrasound scans and baby delivery facilities will follow. The project is sponsored by Samsung.

Source: The Cape Argus



## REACTION: GAUTENG HEALTH RECOVERING WELL; TWO SCANS TO INTERPRET GAUTENG HEALTH; CRISIS AT ITS WORST EVER

According to The Financial Mail Health MEC Hope Papo said Section27/TAC's report was based on old data, and that many of the problems had been fixed. He claimed: 'electronic gatekeeping' was introduced to eliminate unnecessary tests; a processing centre will be established to manage procurement, supply chain and payments; and staff will be vetted to ensure they have no conflicts of interest and are not corrupt.

According to Papo:

- Human Resources: 752 nurses, 595 clinical professionals, 528 allied professionals, 41 allied support staff, 71 management staff, 397 administration staff and 144 support staff were appointed. Medical and allied trainees who completed their community service were absorbed against funded vacant posts. These included 739 professional nurses, 80 medical practitioners, 30 pharmacists and others.
- Infrastructure and Equipment: The department spent more than R12-m to provide critical equipment to its central hospitals. At Charlotte Maxeke equipment like boilers, generators and gas sterilisers were replaced and the oncology unit is fully functional. At Bara, medical and ICU wards have been refurbished. Maintenance work was also done at Dr George Mukhari Hospital in Ga-Rankuwa. An equipment survey is under way to identify old and defunct equipment.
- Availability of medicine: The availability of



**THE AVAILABILITY OF ESSENTIAL DRUGS HAS BEEN IMPROVED FROM 40% TO 76%**

essential drugs has been improved from 40% to 76%. The department is preparing for the introduction of fixed-dose combination ARVs and is expecting to receive 60 000 units of the drug in March.

- Budgeting and financial management: By the end of January, R4,2-bn had been paid to service accruals. A total of 34 927 invoices were paid within 30 days between April 2012 and January 2013. R250-m of cash is ready to be released to suppliers. About 99% of the total accruals that were owed have been settled.
- Accountability and discipline: Following an investigation of tender fraud, the department has taken disciplinary action against 3 senior management officials and several disciplinary hearings are taking place.
- Neonatal deaths: Retired nurses have been

appointed to assist in hospitals and clinics. Perinatal mortality rate (death of neonates from birth to 28 days) was down to 26,7/1 000 in 2012 from 28,7/1 000 in 2011.

However on March 14, Papo admitted to the standing committee on public accounts in Johannesburg that the province's health crisis is at its worst ever this year. He told the committee that he had introduced a biometric verification system to catch "ghost workers". Employees were asked to undergo fingerprinting to verify whether it matched their details in the employment profiles.

More Reaction: Jack Bloom, the DA's spokesman in Gauteng, said credit must be given to Papo as he had addressed some of the glaring issues. But, he has yet to release the findings of a forensic investigation into suspected financial irregularities at the Auckland Park depot.

Source: *The Times; The Star; The Financial Mail*

## GAUTENG HOSPITALS: NATALSPRUIT: FROM R20-M TO R2-BN; SOWETO HOSPITAL UNVEILS WORLD CLASS EQUIPMENT

The New Natalspruit Hospital was supposed to cost just R20-m according to the 2003 Gauteng budget. Instead, the cost is now more than R2-bn - 100 times more than the planners had thought. In 2010, the building costs were R1,47-bn and equipment was estimated at R220-m. However, since 2004 and including this year's budget, R1,595-bn was spent on the hospital and R410-m on equipment.

\*The Clinix Tshepo-Themba Private Hospital

in Soweto has unveiled its new kidney and dialysis clinic with 11 dialysis chair-beds and the latest 5008s dialysis machine. The hospital collaborated with Fresenius Medical Care - one of the world's largest providers of products and services for dialysis patients - to build the clinic. The group has 8 hospitals in Gauteng, 4 of which - including Tshepo-Themba - have dialysis clinics.

Source: *The Star*

## CUBA STUDENTS: MINISTER CLAIMS PLOT

The interception of e-mail communications between SA and Cuba indicated that a conspiracy lead to 187 of the 1 200 students who are part of the SA-Cuba doctor training programme going on a hunger strike and storming the SA embassy in Cuba. The students demanded that their \$200 monthly stipend be increased to \$500. Motsoaledi said three of the six specific students who were recalled, have returned to SA. He said the scholarships of the other three students, who remained in Cuba, will be recalled.

Source: *The Times*

### LIMPOPO: DEPARTMENT CANNOT VOUCH FOR R739-M SPENT; EX-HEALTH MEC CHARGED REGARDING R16-M FRAUD



The Limpopo health department has failed to account for R739-m of taxpayers' money spent illegally on tenders and contracts in the financial year that ended last March. MEC Norman Mabasa said the documents could not be retrieved "because of the challenges in our filing system". She said her department had suspended chief financial officer (CFO) Friday Mushwana for failing to provide essential documents required by the Auditor-General. Mafubedu was asked to provide names at a later stage.

- Meanwhile former Limpopo health MEC Miriam Segabutla appeared in the Polokwane Magistrate's Court (27 March) on charges of fraud and corruption relating to R16-m worth of contracts awarded to two companies owned by her associates, Jonny Lucas and Peter Erasmus, without being advertised. A spokesman for the Hawks (SAPS' elite investigating team), Captain Paul Ramaloko, said they had a strong case based on information unearthed by the Limpopo anti-corruption task team set up by the cabinet.

Source: *The Star*

### DENTISTS WELCOME PROBE WITH TEETH



The probe into private healthcare has been welcomed by dentists. Recent SA Medical Association research showed that of the R93,2-bn spent by schemes in 2010, R34,1-bn went to private hospitals and R12,1-bn to non-healthcare costs such as administrator and broker fees. Medical specialists received R21,3-bn, while general practitioners and dentists were paid R6,8-bn and R2,6-bn respectively. Maretha Smit, CEO of the SA Dental Association, said dentists were not adequately reimbursed as oral hygiene was low on medical aid priority lists while set-up costs and equipment were exorbitant.

Source: *The Star*

### DOH TO STANDARDISE TRAINING OF NURSES; HEALTH AUDIT SHOWS CONDITIONS NURSES HAVE TO DEAL WITH

A standardised nursing sector could be in sight as the DoH has launched a strategy to improve monitoring of nursing institutions and new nurses, and do away with "illegal nursing training colleges". Health Minister Motsoaledi said a "chief nursing officer" would soon be appointed in his office to deal with nursing in hospitals and to monitor progress of the strategy. It is believed nurses were placed in Gauteng hospitals without proper vetting of their qualifications, which may have come from fly-by-night institutions. New regulations stated that, by 2015, all nursing colleges would have to register as higher education and training institutions with the Council of Higher Education. This meant about 300 operational nursing colleges would not only be regulated by the SA Nursing Council, but would also have to meet university standards.

- According to a recent audit 93% of maternity wards did not have functional and essential equipment to keep mothers and newborns safe leading to a high child mortality rate. The Democratic Nursing Organisation of SA (Denosa) warned that relationships between the community and health professionals were deteriorating, due to these infrastructural problems as communities often believed that nurses were to blame for the wrongs that occurred in healthcare facilities. Staff morale was affected by non-payment, shortages and unreliable supplies. The union also supports the SA Medical Association's Positive Practice Environments campaign for tighter compliance with procurement for health infrastructure.

Source: *Business Day; The Times;*  
Editorial comment: *The Star; SAPA*







# DEPARTMENT AWARDS FIRST HEALTH PHD SCHOLARSHIPS

**THE DOH HAS TAKEN ITS FIRST STEP TOWARDS REALISING ITS PLAN TO PRODUCE 1 000 PHDS WITHIN A DECADE**

The DoH has taken its first step towards realising its plan to produce 1 000 PhDs within a decade, announcing the 13 candidates to get scholarships for their research. The recipients of the funding for health PhDs are employed at universities and the Medical Research Council, and each one will be investigating a project within a different category of health research. The researchers are to get full funding to match their salaries. A sum of R15-m has been set aside for the first year of the programme: R5-m from the DoH and R10-m from the private sector via the Public Health Enhancement Fund launched by the Minister last year.

Source: *Business Day*



## Medical Aids

### R22-BN MEDICAL AID RIP-OFF; CALLS FOR ACTION ON MEDICAL AID FRAUD

Corrupt healthcare practitioners are defrauding medical aid schemes of as much as R22-bn a year. This comes after a report that the Board of Healthcare Funders (BHF) had convened a two-day conference to discuss the crisis of soaring medical aid fraud. An analysis of two-and-a-half years' worth of data had been done to arrive at the estimated fraud. According to the head of information analysis company SAS, Chris McAuley, each member of a medical scheme in SA was effectively paying between R2 500 and R2 800 a year to cover fraudulent and irregular expenditure.

Bertha Peters-Scheepers of the HPCSA said the council worked closely with the BHF and medical schemes when they were investigating matters of fraud where doctors, hospitals and patients work in cahoots.

Common methods used to defraud medical aid schemes include: doctors billing for multiple procedures, instead of using one billing; a radiology practice billing medical schemes for disposable gowns for every patient, irrespective of whether the patients needed a gown; patients being sent for unnecessary blood tests, scans and other diagnostic procedures; and short-term insurance paying cash for days spent in hospital. (Also read HealthView and attachment: mschemes13)

Source: *The Times; The Cape Argus*



### GOVERNMENT EMPLOYEE'S MEDICAL SCHEME (GEMS) REQUIRES EARLIER SUBMITTING OF CLAIMS



GEMS is urging healthcare providers to submit claims in accordance with the Medical Schemes Act and the Rules of the Scheme which require that claims be submitted not later than the last day of the fourth month in which the service was rendered. Claims submitted after this period will not qualify for payment. Schemes will be notified of erroneous claims within 30 days and should rectify and resubmit the claim within 60 days.

Source: *The Financial Mail*

# SIZWE MEDICAL FUND AND SECHABA MEDICAL SOLUTIONS AT LOGGERHEADS



The curator of the Sizwe Medical Fund, Khaya Gobinca is still at loggerheads with the scheme's administrator, Sechaba Medical Solutions. Sizwe was placed under provisional curatorship after its board of trustees had failed to address allegations of fraud relating to the election of two trustees in December 2010. The latest problem is a decision by Sechaba to defy an instruction by Gobinca to charge a 30% co-payment on claims by members who did not use the designated service providers across all options. Sechaba said this contradicted the scheme's 2013 rules and Gobinca's decision last year that the 30% co-payment would apply only to the scheme's primary option. Sizwe is Sechaba's only client.

Source: *The Financial Mail*

## Medical Aids

DAVID JACKSON, BUSINESS DAY INSIGHTS

## LACK OF **TARIFF** LIMIT POSES **THREAT TO SCHEMES, MEMBERS**

A legal action instituted jointly in 2011 by the Board of Healthcare Funders (BHF) and the South African Municipal Workers' Union (Samwu) medical aid scheme gets to the heart of the pricing impasse over prescribed minimum benefits (PMBs) within the healthcare sector.

The action is based on the contention that the Registrar of the Council for Medical Schemes (CMS) cannot hold - as Regulation 8 of the Medical Schemes Act does - that benefits have to be paid in full at whatever fee the doctor charges for such prescribed minimum benefits (PMBs).

Dr Humphrey Zokufa, CEO BHF: "We believe that there has to be some kind of limit - and the minimum limit in the act is set at what is at least available in the public sector, at the same level of reimbursement." The Board of Healthcare Funder's (BHF) position - on which it has sought a declaratory order - is that to protect medical schemes and their members in the long run, there has to be some form of tariff limit on PMBs. The BHF contends that if the CMS' regulation was allowed to gain traction - and in

the context of no tariff - there would be no limit constraining healthcare service providers on what they could charge for PMB.

Heidi Kruger, BHF's Head of Corporate Communications: "As a result of there being no set tariff in place in the healthcare market, we are seeing price blowouts occurring across the sector, especially for specialists' services - and sometimes price hikes in the order of 400% to 500%. Without a proper court judgment, the potential is there for all doctors to do likewise."

"... we would at least have some form of ceiling price in place."

The content of the PMB package was influenced by two major policy positions: protection from financial ruin for members and to safeguard against "dumping" of sick people needing medical care onto the state sector.

The amount that is being spent by medical schemes reimbursing hospitals and specialists for PMBs is up to 80% of the income of private sector healthcare organisations in some instances, she says.



**WE BELIEVE THAT THERE HAS TO BE SOME KIND OF LIMIT - AND THE MINIMUM LIMIT IN THE ACT IS SET AT WHAT IS AT LEAST AVAILABLE IN THE PUBLIC SECTOR, AT THE SAME LEVEL OF REIMBURSEMENT**



## HEALTHCARE MUST BE SEEN AS A 'PUBLIC GOOD'

The BHF supports the initiative by the Health Professions Council of SA (HPCSA) to arrive at tariffs for healthcare services. The HPCSA, as a statutory body, must ensure that the rights enshrined in Section 27 of the Constitution are enjoyed by the entire population through appropriate regulation of healthcare service providers, says Kruger.

The process by the HPCSA should lead to a regulated pricing and coding mechanism and not a "guideline tariff" as is envisaged. She says: "A regulated pricing mechanism provides protection for consumers and certainty for healthcare service providers, funders and consumers."

The practice of "unbundling" or manipulation of codes maximises revenue for the service provider without having to add extra value to the member/patient, the BHF says. The BHF urged the HPCSA to launch an investigation into the extent of the "perverse billing practice".



# STRATEGY TO MAKE PEOPLE HEALTHIER

Discovery's Vitality programme aims to create tangible incentives through multiple rewards and programmes, to get people to live more healthily. This has had a meaningful impact on peoples' health, on healthcare costs and on mortality rates, across a population of about 1,7-m Vitality members in SA, says Gidon Novick, CEO of Discovery Vitality

The programme is up and running internationally in the US, the UK and China, in addition to SA, underlining the fact that cultivating healthier lifestyles is a huge global issue.

Vitality has a strong focus on promoting healthy food consumption, through a programme that incentivises people to make healthier food choices when shopping. This facility is available at Pick n Pay and, from next month, at Woolworths as well.

"Vitality members will get up to 25% off all the healthy food items they select in the store," says Novick. "We have already seen a 10% shift in people's basket mix as they move towards a healthier food selection. We have been able to track a direct correlation within our base between physical activity and the likelihood of being admitted to hospital."



## SOLUTIONS TO HELP MEMBERS MAKE APPROPRIATE CHOICES

Despite the popular misconception that medical schemes are mainly for the sick and elderly, the reality is that medical schemes play a pivotal role in helping people maintain and manage their health so they can live healthier, longer, productive lives.

"Liberty Medical Scheme (LMS) is all about health solutions that empower members of all ages to make appropriate choices in support of a good life," says Andrew Edwards, executive principal officer for LMS. LMS covers various preventative procedures and vaccinations to help protect against diseases that could impact on quality of life - and financial wellbeing.

The LMS AIDS programme is dedicated to ensuring the physical and emotional wellbeing of HIV-positive members by offering treatment as well as counselling. Its smoking cessation programme helps members kick the habit, while the LMS baby and maternity programme also offers additional benefits for new and prospective mothers.

# EMPLOYEES CAN SAVE MONEY ON THEIR CONTRIBUTIONS

Many companies allow their employees to choose their own medical scheme and it is in their interest to save money on their monthly contributions, yet many don't know how to do this. According to Rod Hallowell, principal officer at CompCare Wellness Medical Scheme, members should: assess the healthcare needs of their families and compare them to the various benefit options offered by other schemes; and have a closer look at the various options their own medical scheme provided. If a medical scheme was proactive and innovative enough it should offer products that could reduce the cost of existing cover, while ensuring premier quality of care. Members could, for instance, reduce their monthly contributions by as much as

18%-30% on five of CompCare's benefit options by selecting Netcare as their preferred provider for elective in-hospital services and Dis-Chem for self-collect or courier delivery of chronic medication.

Medical scheme members should also pay close attention to their schemes' reserves: Where administration costs were low and reserves high, contribution rate increases were kept below the market average. The working partnership between an administrator and a medical scheme was also important when it came to offering value for money.

Source: Loraine Tulleken: Business Report



# HOW TO SURVIVE YOUR MEDICAL AID

Medical aids are hiking their contribution rates at 8,9% a year - far above inflation - forcing people to think creatively about how to slash their own medical aid costs. The above-inflation medical aid hikes are a cocktail of the rising costs of medicine, expensive new medical technology, hospital rates and a chronic shortage of doctors and nurses that are causing their fees to spike. Another huge problem is medical aid fraud - estimated to cost each member R2 500 per year or R22-bn per year.

However, Discovery Health CEO Jonathan Broomberg, estimated that less than a fraction of 1% of health professionals were involved in fraud.

Lynette Swanepoel, manager at the BHF, said the fee-for-service model used by SA medical aids incentivised the "over-servicing" of patients, which added to the problem.

In the first KPMG survey, carried out from 2001 to 2003, only 49% of medical aid administrators said they did not keep quiet about fraud cases. But by 2009, every administrator said fraud was now reported and there was a zero-tolerance approach. Most medical schemes have dedicated forensic investigative units.

**DOCTORS BEHAVING BADLY:**

Only a small number of doctors and dentists try



to defraud medical aids every year, but the cost amounts to billions. Here are some ways in which they do:

**DOCTORS OR DENTISTS:** submit claims for consultations that would have lasted for more than 24 hours in any single day; provide one service to a patient, but then add on procedures that they have not performed; over-serve a patient by: MRI scan when only basic medication was needed.

Pharmacists sell groceries to people and then submit claims to the medical aid; sell generic products to members but submit claims

for more expensive branded products;

**IN GENERAL:** Claims have been submitted for computer classes under the guise of it being a "therapy session"; poorly equipped laboratories have submitted fake claims for work done; and abuse of the hospital plan: the patient is admitted to hospital with a vague complaint such as backache. The medical aid pays the claims and the insurer pays cash to the patient.

**PATIENTS BEHAVING BADLY:**

Failure to disclose an accurate medical history upfront; members also lie about their income when premiums are based on how much they earn; syndicates that work on ripping off schemes: people join a medical aid and, before they have paid their first premium, they submit a claim that is paid to their bank account: they never pay that first premium; members sometimes go to a doctor and they collude to extort cash; hospital clerks collude with members in hospital cash plans: clerks admit members to the hospital - although he or she does not actually stay in hospital - and the medical aid payment is then split with the syndicate; and, card sharing: members give their cards to a relative who needs to see a doctor or other health professional - not covered by the scheme.

Source: Adele Shevel: *The Business Times*

## SETTING BENCHMARKS FOR PRIVATE SECTOR SCHEMES

GEMS the government employee's medical scheme is setting benchmarks in the funded healthcare industry. With approximately 700 000 principal members, representing approximately 1,9 million covered lives, the scheme has enjoyed unprecedented growth since its launch seven years ago. Liziwe Nkonyana executive for communications and member affairs, strongly advocates a "no frills" approach: good value, great benefits and accessibility. Nkonyana advises, when choosing a medical scheme that the following be considered:

1. How affordable is your medical scheme? It is always better to choose the cover that is also most appropriate to meet your needs.

- 2. Are you getting true value for money from your medical scheme? Always enquire what the average scheme increases were over the past five years. Check if benefits were decreased or increased as some schemes may well reduce benefits while increasing contributions.
- 3. How does your scheme square up in terms of benefits? Check what you are covered for and which waiting periods are applicable to you.
- 4. How accessible is your medical scheme?

- 5. How well do you understand your benefits?
- 6. How innovative is your medical scheme?
- 7. Does your scheme listen and act on the suggestions of its members?





## CHEAP DRUGS A BITTER PILL FOR THE WEST

Since Uganda began making its own medicine in 2007, it has produced not only anti-malarials, but also anti-retrovirals (ARVs). This was made possible in part because Uganda is considered a "least-developed country" who does not yet have to respect international intellectual property laws, set out through the World Trade Organisation's, and was given until July to adopt the agreement's measures. Middle- and high-income countries, SA included, have to give strong patent and copyright protection.

According to Jamie Love, director of Knowledge Ecology International, several big drug companies had either abandoned enforcement of the patents in least developed countries, or grant voluntary licences.

Almost 80% of first-line ARVs used in the developing world is produced in India. Mozambique also plans to produce ARVs and other medicine.



Meanwhile a letter was signed by nearly 400 organisations, including many from SA, voicing their support of the indefinite extension of an agreement. A final decision on the matter is expected in June.

Source: Mail & Guardian

## ANTIBIOTICS CRISIS PROMPTS RETHINK ON RISKS AND REWARDS



Antibiotics have become victims of their own success. Seen as cheap, routine treatments, they are overprescribed and taken haphazardly they create "superbugs" they can no longer fight. The costly research needed to combat superbugs is not worthwhile as they have not yet spread widely. Fixing the problem will need both faster approval of last-resort drugs and new ways to guarantee rewards for companies, according to both industry leaders and public health officials who have been sounding the alarm.

- Public-private alliances across countries could change the conventional market model, said Andrew Witty, CEO of GlaxoSmithKline, one of the few Big Pharma companies still actively researching antibiotics. He has made an offer to England's chief medical officer, Sally Davies, to create new laboratories for developing research ideas brought in by others. New market approaches could include doing away with a price and instead having the healthcare system paying the inventor a fee per year as a reward for delivering a medicine. Davies said the steady rise in resistance in the last five years represented a "ticking time bomb" that ranked alongside terrorism as a threat to the nation.

Source: Reuters

## AFRICA'S FIRST CLINICAL STUDY SITE, IN SA WILL BOOST MEDICAL RESEARCH

Africa's first clinical study site in Cape Town, developed by Novartis and UCT's H3-D drug discovery and development centre, will enable SA to deliver drugs ready to be tested on human patients. H3-D developed the first compound approved by the Medicines for Malaria Venture (MMV) as a pre-clinical anti-malaria candidate drug in July last year. The director of H3-D, Kelly Chibale, said the MMV's team of scientists had expanded from 4 to 22 people. The centre, due to open later this year, was funded by the Department of Science and Technology and the Technology Innovation Agency funded the MMV project and centre.

Source: Business Report

## US GENERIC DRUG MAKER CHALLENGES JURY AWARD

US Supreme Court will hear arguments in a case that could decide whether generic drug makers can be held liable for alleged flaws in the designs of their medications, even though federal law requires generic manufacturers to copy the design of the brand drug maker. Mutual Pharmaceutical has asked the court to overturn a \$21-m jury award to Karen Bartlett from New Hampshire who took Mutual's generic non-steroidal anti-inflammatory drug, sulindac, in 2004 for shoulder pain. The reaction to the drug left Bartlett with permanent near-blindness, scarred lungs and a constricted oesophagus that makes it difficult to swallow. Asking the Supreme Court to overturn the award, Mutual is arguing that federal law bars such claims because its drug had already been approved by the US Food and Drug Administration and federal law requires generic drugs to have the same design as their brand name equivalents.

Source: Reuters

# SA MUST FOLLOW BRICS LEAD ON PATENTS

The Treatment Action Campaign (TAC) and Médecins Sans Frontières called on the SA government to follow the lead of its Brics peers to ensure that life-saving medicines are affordable. SA's patent system currently does not take advantage of flexibilities for protecting health, like overriding patents with a compulsory license (CL) when drugs are priced out of reach for those in need.

SA has never issued a CL - despite being a major purchaser of antiretroviral drugs and TB treatment. SA's patent registration system, does not

scrutinise patent applications, and often grants multiple patents on the same pharmaceutical ingredients. By protecting poor-quality patent monopolies of pharmaceutical companies, SA cannot obtain more affordable generic medications available from Brics countries like India, nor develop substantial local pharmaceutical production capacity. Despite SA government assurances that a new law is in the works, the deadline for the draft law to be made public and opened for comment has been repeatedly missed.

*Source: Media Release via Health-e News Service*

# COSMETIC MEDICINE

Allergan, the largest cosmetic medicine player in the local industry, says due to the growth of the middle-class on the African continent, the anti-ageing market is anticipated to reach about \$274-bn this year, with more than \$100-bn of that devoted to aesthetics. SA is one of its highest growth markets right now after experiencing 25% growth in its dermal filler treatment for lips and 10% on botox last year.

*Source: Business Report*

## Financial News

### LITHA: EASE THE PAIN; EARNINGS PLUNGE ON WEAK RAND, SLOWER SALES TO THE STATE



Last year's depreciation of the rand against the dollar - and a slump in sales - hit Litha Healthcare hard, sending headline earnings per share for the year ended December tumbling 78%. About 84% of Litha's business was regulated by the single exit price. Litha's bottom line was affected by the costs of its acquisition of generic pharmaceutical company Pharmaplan.

The company is tagging the possibility of delisting from the JSE to a proposed black empowerment deal. If it does, minority shareholders will be offered 390c/share. Litha is looking at a 52,5% stake in the Biological & Vaccines Institute of Southern Africa (Biovac). Biovac distributes a variety of vaccines on behalf of the SA government, but will soon start manufacturing vaccines from a plant in Pinelands in Cape Town. Litha will now be consolidating operations and building its product base rather than focus on growth.

*Source: Business Day; The Financial Mail*

### CIPLA INDIA'S OFFER FOR SA FIRM RAISED; BEE SURPRISE MAY LIE AHEAD; BONDING; RESTATEMENT TO HIT CIPLA SHAREHOLDERS WANT SIGHT OF CIPLA MEDPRO SUPPLY DEAL; CIPLA RESULTS: PAYOUT BITES INTO EARNINGS

Among the issues complicating the decision for Cipla Medpro (CMSA) shareholders on the bid by Mumbai-listed Cipla to acquire 100% of its shares, is Cipla Medpro's 20-year supply agreement with Cipla India, which expires in November 2025. The deal (including a confidential contract) lies at the heart of Cipla Medpro's business, as it secures a pipeline of generic medicines from Mumbai-based Cipla. A shareholders' meeting to vote on the deal is planned for April 30.

The Cipla India bid is valued at R4,5-bn. The deal aims to strengthen Cipla's position in the SA market and support its expansion into the rest of Africa. The Indian company has a turnover higher than \$1,4-bn; has more than 34 plants across India; and makes more than 2 000 products supplied to about 170 countries.

Shareholders of CMSA are likely to accept the buyout offer of R10/share for the whole company. CMSA's shareholders include BEE consortium Sweet Sensations, Sanlam and the Public Investment Corp.

Chairman Sbu Luthuli said Cipla India would support BEE. CMSA won the largest portion of the government's antiretroviral (ARV) tender last December; R1,4-bn.

Results: CMSA's profit for the year to December slide to R168,4-m from R238,9-m. Two major contributors to the poor performance were the settlement costs that Cipla had to pay to Reckitt Benckiser SA as well as the restatement of the group's amortisation and impairments on intangible assets for 2011. Cipla won government tenders with a combined value of about R1,448-bn, a significant increase from the previous ARV tender, in which it won R633-m. Tender business with the government may exceed R2-bn over the next two years. CMSA's group revenue grew 30% to R2,3-bn, underpinned mainly by increased supply of ARVs to the state, private market growth of about 13% and growth in other operating segments of about 34%.

*Source: Business Day; The Financial; Business Report*



## DISCOVERY: NO SLOWDOWN WITH AGE



The Discovery Health Medical Scheme may find it difficult to grow exponentially from its high base, but it has proved hard for competitors to poach its members. The lapse rate fell from 3,9% to 3,2%. The scheme added 400 000 members over the past three years as it has grown to more than 2,5-m. Discovery Life, which used to consume lots of cash, has turned cash positive. But the group will need to keep the taps running for Discovery Invest and the short-term business, Discovery Insure. Discovery looks well entrenched in its core business, and may be the pick of the life insurance sector for the long-term investor.

Source: *The Financial Mail*

## DRAMATIC BID TO BUY ADCOCK; BIDVEST SETS A TOUGH ONE FOR SHAREHOLDERS; ADCOCK INJECTION

Brian Joffe's Bidvest Group is offering Adcock Ingram R6,2-bn for 60% of the group. Joffe's company is offering cash of R65/share for 30% of Adcock, and 1 Bidvest share for every 4 Adcock shares for the other 30%: R61/ share, given Bidvest's share price. After the offer, Adcock's share price shot up 9,2 % to R61,40, valuing the company at R11-bn. Analysts believe Bidvest could be the catalyst to inject renewed energy into Adcock. Although opportunistic, Bidvest's offer it is not cheap. Adcock's board has five working days to decide to co-operate: 75% of shareholders have to vote in favour. Offer terms will be adjusted downwards if Adcock's interim earnings are not at least R2/ share. The offer won't be higher if the earnings are above R2.

Source: *Business Report; Business Day*

## ASPEN SEES BOOST FROM ASIA-PACIFIC; ANOTHER SOLID YEAR

Aspen Pharmacare's Asia-Pacific business grew revenue by 18% to R3,4-bn, due to its acquisition of new products in Australia and organic growth in Asia. Aspen launched a subsidiary in the Philippines last year, and plans to extend its reach into Malaysia, Japan, Taiwan, Thailand and India.

Despite the weak rand and modest price hikes, the business in SA reported a 24% increase in revenue and its domestic consumer business a 17% increase, driven by increased sales of infant milk. The group was selling R100-m/month worth of ARV drugs a month to government in the previous tender. That will now shrink to R60-m/month. However, the demand for the three-in-one molecule is likely to increase and Aspen is one of the three companies contracted to produce the new pill.

Discussions to acquire an active pharmaceutical ingredients plant and a portfolio of related products in the Netherlands from MSD may mark its entry into Europe.

Source: *Business Day; The Financial Mail*

## General News

### DAY HOSPITALS: SHIFTING TRENDS



While SA's big three private hospital groups, Life Healthcare, Medi-Clinic and Netcare, have traditionally focused on sophisticated acute operations, some independents have been carving out a niche by establishing day hospitals and integrated primary healthcare facilities. In the past six years they have grown from 14 to 28 independent day hospitals. Intercare Medical & Dental Centres operates 15 medical & dental centres, 3 sub-acute hospitals and 2 day surgery facilities. Day hospitals are increasingly being preferred by medical schemes, as they don't have to pay for patients' overnight costs in a hospital.

Source: *Financial Mail*

### MEDICAL DEVICE INDUSTRY SAYS REVISED BEE CODES 'UNFAIR'

The SA Medical Device Industry Association (SAMEDI), representing 150 suppliers and importers of equipment and devices from abroad, expressed its reservations on the proposed amendments to the broad-based BEE bill. SAMEDI chief operating officer Tanya Vogt said the bulk of the targets and criteria made achievement in ownership, skills development and supplier development near impossible. Financial commitments and business changes required by the draft codes could not be achieved within of a year or two. SAMEDI proposed that the implementation of the amendments be delayed as more research was needed to ensure that the codes had a fair application. It also proposed that the skills development element of the codes be amended to include in-company training of healthcare professionals that falls outside the proposals.

Source: *Business Day*

### COST OF 'TELEHEALTH' REDUCES ITS VIABILITY

Monitoring patients at home using modern technology, so-called tele-health, is tipped as the next big thing in healthcare. But a new study by Prof Martin Knapp from the London School of Economics, suggests that it may not be worth the extra expense. Researchers found that the cost per quality-adjusted life year - a standard measure of quantity and quality of life - of tele-health when added to usual care was \$139 200; well above the £30 000 that Britain's National Institute for Health and Clinical Excellence uses as a benchmark for assessing whether medical interventions are worth using in the state-run health service. This has led to controversy as British Health Minister Jeremy Hunt announced plans in November 2012 to roll out tele-health to 100 000 people with a long-term condition in 2013 and have three million on the system by 2017.

Source: *Reuters*

# HOW ARTIFICIAL FLIES ARE MADE

## THE HISTORY OF THE FISHING FLY

Fly fishing is an interesting sport with a growing number of people participating. When people start out fly fishing they usually just buy all of the gear that they need, including their artificial flies (also fishing flies).

Once people get hooked on fly fishing though they often start thinking about making their own artificial flies as a way to stay involved with the sport during the off-season months.

While some artificial flies can be tricky to make others are actually well within the abilities of the average fly fisher. Even children can learn to tie artificial flies and this is an excellent way to get them involved in the sport.

The earliest description of tying artificial flies dates back to the 2nd century. Macedonian anglers, fishing on the Astraeus River, had devised a method of fly fishing using artificial flies.

These Macedonian fly fishermen started with a hook and then tied red-dyed wool around the hook. They would then tie small feathers onto the red wool to complete the artificial fly. Apparently these fishermen were quite successful with their primitive artificial flies.

*To continue reading this article click here:*  
[http://www.flyfishinginformation.net/How\\_Artificial\\_Flies\\_are\\_made.html](http://www.flyfishinginformation.net/How_Artificial_Flies_are_made.html)



Medscape  
One-on-One



# EVENTS



Event	Date	Location
American Transplant Congress	May. 18, 2013 - May. 22, 2013	Seattle, WA , USA
9th International Symposium on Pediatric Pain	Jun. 17, 2013 - Jun. 20, 2013	Stockholm, Stockholms Lan, Sweden
90th Annual Canadian Paediatric Society Conference	Jun. 19, 2013 - Jun. 22, 2013	Edmonton, AB , Canada
3rd paediatric Neuropsychology symposium	Late In 2013	TBA
Society for Pediatric Dermatology 39th Annual Meeting	Jul. 11, 2013 - Jul. 14, 2013,	Milwaukee WI , USA
Options VIII: Options for the Control of Influenza	Sep. 5, 2013 - Sep. 10, 2013	Cape Town, Western Cape, South Africa
9th Joint Meeting of Paediatric Endocrinology	Sep. 19, 2013 - Sep. 22, 2013	Milano, Lombardia , Italy
The Society for Developmental and Behavioral Pediatrics 2013 Annual Meeting	Sep. 27, 2013 - Sep. 30, 2013	Baltimore, MD , USA
9th International Forum on Pediatric Pain	Oct. 3, 2013 - Oct. 6, 2013	White Point, NS , Canada
8th World Congress on Pediatric Infectious Diseases	Nov. 20, 2013 - Nov. 23, 2013	Cape Town, Western Cape , South Africa
8th world congress of the world society for Paediatric infectious Diseases	19 - 22 Nov	Cape Town ICC
Annual international Paediatric surgical Research symposium	29 - 30 nov	Sports science intitute of South Africa, New-lands



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**Paediatric** **NEWS**

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