SUMMARY OF HEALTH NEWS: DECEMBER 2011

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1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

Debate on NHI must progress beyond ideology

Mariné Erasmus: Business Day, 14 December 2011

The keynote address by Health Minister Aaron Motsoaledi at a recent NHI conference highlighted three of the major problems in the South African health system, namely **hospital centrism, fragmentation of health services and uncontrolled commercialism.** Motsoaledi once again committed to strengthening the health system; focusing on two prerequisites for the proposed NHI to be successful: **improving the quality of healthcare in the public sector and addressing the high costs of healthcare in the private sector.**

The international speakers shared experiences from a number of developing and developed countries regarding **the financing, service provision, institutional arrangements and governance options of their respective national health systems**. The National Treasury's deputy director-general for public finance, Andrew Donaldson, reminded delegates that options to increase any form of taxation (be it sin taxes, VAT, payroll or general taxes) are limited in our specific context. Public-private split of healthcare expenditure in SA was inequitable. "One is left with a similar feeling to that evoked by reading the NHI Green Paper: **impressed with the government's efforts to move forward with the proposed NHI system, but questioning the contribution to facilitating engagement with many of the real issues**. Once again, most aspects were addressed only at an ideological level."

Erasmus is a senior economist at Econex

Failure a symptom of fragmentation

The Cape Argus, 9 December 2011

The fundamental problem with the SA health system, is that t**he country's health resources are clearly not distributed according to the population's health needs.** The problem derives from the way financial flows in the system are fragmented. **Health insurance is intended to enable redistribution of services and resources from the collective of contributors to those who need them in any particular year.** When a system is fragmented, it means that there are barriers to the extent to which this redistribution can occur.

In most high income countries with explicit forms of health insurance, such as Germany, Japan, the Netherlands, and Switzerland **the poor population is part of the same insurance pool as the rest of the population**, regardless of their income.

Because the contributions to medical schemes in **SA are pooled only on behalf of scheme members, the actual redistribution from healthy to sick is much less than what would be**

possible if there were no barriers to the redistribution potential of all prepaid revenues (from taxes and medical scheme contributions) on behalf of the entire population. The medical schemes are not doing anything wrong; they are **just following the rules of the existing system**.

One lesson flowing from the international experience reviewed in WHO's World Health Report is the **importance of both increasing the size of the prepaid pool and expand the scope for redistribution that is possible from the prepaid funds.** One approach being considered would introduce **a new payroll-linked mandatory contribution for NHI**, and **pool the funds raised from this with allocations from general revenues (allocations that currently flow directly to government health facilities).** The new mechanism would enable at least some of the spending that employers and employees currently devote to medical schemes to flow into the national pool, and together with the general budget transfers, will greatly enhance the scope of the national system to redistribute resources to where they are most needed. The funding mechanisms proposed for the NHI would thus reduce a major source of fragmentation in the system.

Joseph Kutzin is co-ordinator of Health Financing Policy at the WHO

'Health is not about deep pockets';

The Star, 8 December; Business Day, 9 December 2011

Speaking at the opening of the National Consultative Health Forum's NHI conference, Organisation for Economic Co-operation and Development, economist Ankit Kumar said **SA could learn a few lessons from South Korea,** which achieved **universal coverage for the entire population in just 12 years.** In the 30 or so years since South Korea started reforms towards NHI its GDP was six times what it was in 1970 and **life expectancy had increased by 20 years to 80 years, on average**. South Koreans started the rollout of health insurance with the **informal labour market before gradually expanding coverage to the formal labour market.**

Poor will bear cost of NHI scheme; DA wrong about NHI

Business Day, 7 December 2011; SAPA, 7 December 2011

Speaking at a media briefing on the NHI scheme, DA parliamentary leader Lindiwe Mazibuko said the **poor would suffer more under the NHI because it would divert billions of rand from other development challenges such as the provision of basic services, education and housing.** DA health spokesman Mike Waters said the creation of a centralised fund would over-bureaucratise the public healthcare system, making it **more inefficient and costly** than it is, as well as increasing the risk of **corruption and financial mismanagement.**

National Assembly health committee chairman Bevan Goqwana reacted by calling the DA's statement "pretentious, reckless, and inconsiderate" of the health needs of the poor. **Mr. Casper Venter, MD of HealthMan consultancy and a spokesman for the South African Private Practitioners' Forum,** said **government needed to make its intentions clea**r on how the NHI would be **funded**. He said if it were funded from general taxes, it would require an average 13% increase in tax revenue or up to a 6% increase in marginal taxes and this was not affordable.

Look again at the role for a transformed private sector (Bernstein)*

Business Day, 30 November 2011

The **co-existence between the public and private health sector is the most contentious aspect of the debate on health reform over the next 14 years**.

According to research on **private healthcare:**

This sector **serves up to 35% of the population**, if out-of-pocket payments are included; it has **smaller human resources** than its critics claim; it r**educes the burden on the public health sector** and has **less "excess capacity" t**han is often claimed; and it f**aces input costs and barriers to market activity** which, rather than "greed", is what drives up prices.

On the other hand, in reforming the public sector, it will be essential to appoint qualified people

to manage the sector. Other initiatives include expanding **training of doctors, a vigorous overseas recruitment campaign, and extending private sector involvement in medical training.**
Launching the green paper on the NHI in August, Health Minister Aaron Motsoaledi said the intent was to **draw on the strengths of the public and private health sectors to better serve the public**. This implies **public-private co-operation; opportunities for private sector specialists to work in the public sector;** a**ccess to quality care by extending the reach of private insurance coverage.**

The following reforms would address the problem of high prices:

1. **Private entities/hospitals** should be allowed to **employ doctors.**
2. All **regulated processes** connected with health should b**e simplified and their administration made transparent**.
3. **Competition should be encouraged,** not stifled by bureaucracy, corruption and anti-market ideology.
4. L**ow-cost healthcare companies from outside SA should be allowed to operate here**.
5. The publication of **price lists for medical services** should be mandatory.
6. The private sector should be encouraged to **operate a wider range of facilities, including lower-cost ones focused on primary care, such as day surgeries and outpatient facilities, with a bigger role for general practitioners and nurses.**

Finding the resources for this is an enormous task when only 41% of the working-age population participates in the formal economy. The challenge can be met only by managing resources.
**** Bernstein is executive director of the Centre for Development and Enterprise (CDE); Johnston is a senior associate at CDE. This article is based on a new CDE report: Reforming Healthcare: What role for the private sector?***

<u>"All unions should rally behind NHI"; Capitalist vultures in DA oppose the NHI</u>
Sowetan, 24 November; Business Report, 9 December 2011
Cosatu has warned that **public-private partnerships in the implementation of NHI will be a route to corruption**. **Outsourcing of administration for NHI would lead to failure to deliver good health service to South Africans,** Cosatu's spokesperson said. Cosatu's statement is based on many public-private partnerships or outsourcing of jobs in government that had led to business making a profit without completing the required work**. Cosatu called for the disbandment of all medical schemes and to channel resources towards the NHI**.
The SACP also lashed out at the private sector saying the **DA was "in the pockets of the capitalist vultures in the private capitalist health sector which doesn't care about the health of the majority of our, people other than to profit from their illnesses".** They called the private health sector "inappropriate and unsustainable for our country".

<u>Cabinet moots health product regulator; The circus lumbers on</u>
SAPA, 24 November; The Financial Mail, 25 November 2011
Cabinet has approved the establishment of the SA Health Products Regulatory Authority (SAHPRA). The new authority will **regulate all health products for humans and animals**. The authority will **ensure the integrity of available health products and indirectly the integrity of the health product industry,** including **pharmaceutical devices and food industries**.
SAHPRA will **replace the Medicines Control Council (MCC)** which has a **backlog of 1 500 drugs** waiting to be registered. It will be run as an i**ndependent body and will manage its own budget, b**ut it will **report to the Department of Health and parliament.** Though government is clear on its plans to address the backlog of drug registrations, Innovative Medicines SA executive director Val Beaumont said there had been **endless discussions, two task teams, three Ministers, a backlog project and new legislation promulgated but not yet implemented, yet the approval process in this country remained one of the longest in the world.**

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

The last word on the Zille saga: Editorial comment: Prof. Steve Robins*

The Cape Times, 2 December 2011

"In recent weeks we have **witnessed a series of animated exchanges between Western Cape Premier Helen Zille and AIDS activists on the question of "sexual responsibility" and the criminalisation of HIV-positive people who knowingly infect others**. Zille remains adamant that those who behave sexually irresponsibly do not deserve free access to expensive, state-funded HIV treatment. In addition, she argues that those who knowingly infect others ought to feel the full might of the law." Zille's many detractors, such as the *TAC*'s Nathan Geffen, challenge these positions and are particularly incensed by Zille's calls for the criminalisation of HIV transmission and the introduction of compulsory HIV testing. **Helen Epstein, the acclaimed author of *The Invisible Cure*, has also criticised Zille's "draconian" approach** on the grounds that it is both unworkable and that it **violates basic human rights** to privacy and dignity. Zille also attracted the ire of activists and health professionals for her controversial "Get tested and Win" HIV campaign whereby **those who test for HIV stand to win prizes in a competition**. While Geffen, Epstein and numerous other activists and health professionals have rebutted Zille's recent HIV statements and interventions, it is **important to situate Zille's unorthodox ideas within the wider context of changes in global health discourse and potentially devastating donor cuts to the funding of HIV programmes in Africa.**

Robins is professor of sociology and social anthropology at the University of Stellenbosch

On the Zille saga, Prof Francois Venter from Wits said he welcomed the move as long as there was counselling. Venter has been critical of Zille's call to file murder charges against those who knowingly infect their partners with HIV.

Exploding the sexual stereotypes

Prof. Francois Venter: The Cape Times, 25 November 2011

According to Prof Venter there is **accumulating evidence that people in our region are more vulnerable to HIV per sex act than our European, Asian or American counterparts**. "There is some evidence that the **HIV subtype in our region may be more infectious longer,** a**nd that our genetic makeup may make us more prone to contracting HIV."** Venter says recent theories include the possibility that **local genital co-infections may play a ro**le, and perhaps even a **nutritional cofactor**. "Its sex; sure; but high risk sex, largely independent of how or with whom you have it."

Prof Venter is a doctor working in HIV, deputy executive director of the Wits Reproductive Health and HIV Institute (WRHI), and outgoing president of the Southern African HIV Clinicians' Society.

Now HIV will face anti-virus software

The Sunday Times, 4 December 2011

Researchers at **Microsoft are using spam-defeating software similar to that used by Hotmail - the world's largest web-based e-mail service - to search for the constantly mutating human immunodeficiency virus.** Like e-mail spam, which is constantly being adapted to evade the latest counter-measures, the many strains of HIV frequently mutate. Antivirus software has been designed to detect the core details of spam - and this ability is being used against HIV. The central research is being done at the University of KwaZulu-Natal.

NEW Plan may halt HIV over 20 years

The Cape Times, 1 December; The Times, 2 December; SAPA, 1 December 2011

The National Strategic Plan to address HIV 2012-2016, launched in Port Elizabeth on International Aids Day, will cost about R131bn. But the Health Department's chief director for HIV/AIDS, Thobile

Mbengashe, said the plan **had the potential to halt HIV over a period of 20 years**. The new plan has very similar aims to the previous one and targets "key populations" most likely to become HIV-positive or transmit HIV. The plan also emphasises testing for HIV and TB, stressing that everyone should have access to annual tests.

Slowdown in global money to fight AIDS cause for concern; AIDS fund 'running out of money; Deadly AIDS outlook (Editorial comment)

The Cape Times 2 Dec; The Times, 29 Nov; SAPA, 28 Nov; The Business Times; 4 December 2011
The global financial crisis has caused a slowdown in global financial commitments to fighting AIDS. About **20% of South Africa's HIV spending** is paid for by The Global Fund, which redistributes money from donor countries such as Italy, the US, and Germany to countries with a high HIV, TB and malaria incidence. The fund had to **put all country funding applications for this year on hold** because of "current resource constraints". SAPA reports that a **$1.6bn cut in funding for AIDS treatment could affect millions of people as donors fail to meet commitments.** The group include South Africa's Budget Expenditure Monitoring Forum, the Treatment Action Campaign (TAC) and Doctors without Borders. This implies that **those newly infected with HIV might get no help**. But what may be worse is that, if those already on the combination treatments come off them, the virus may **become resistant to existing drugs.**
The latest news from The Global Fund is that it has **introduced a stop-gap measure to keep essential services going, but has cut off a lifeline for civil organisations counting on new grants**. The stop-gap, called the transitional funding mechanism, will provide **emergency funds to continue essential prevention**, treatment and care services. The fund hoped to have **nearly $12-bn available, but fell short by $2-bn,** said board chairman Simon Bland.

TAC not closing down; Funding threat
SAPA, 24 November; The Financial Mail, 9 December 2011
AIDS lobby group Treatment Action Campaign **(TAC) is not closing down**. According to the Department of Health **payment to TAC was delayed in July, due to issues relating to their financial report.** Officials of the department were working closely with the TAC to clear outstanding reporting issues, ensuring that the TAC continued with its work.
It is not the only health-related NGO worried about delayed or reduced funding. **Soul City, a health and development communication NGO, received a budget or R13m budget from government this year - R5m less than last year's R18m.**

One third of pregnant SA women at public clinics HIV-positive
Health-e News Service via The Cape Times, 30 November 2011
South Africa still has a very high HIV infection rate among 15 to 24-year-old pregnant women and increasingly among 10 to 14-year-olds.
Meanwhile a **major trial of a vaginal gel** expected to protect women was **stopped after it was found to have no effect on preventing HIV.** The trial started in 2009 and involved more than 4 000 South African women.

Early HIV treatment plan 'game changer'; Trials halted on HIV prevention gel for women
The Cape Argus, 29 Nov; Health-e News Service via The Cape Times, 28 November 2011
According to the results of a trial released in May **sex with an HIV-positive person on ARV treatment with an undetectable viral load is as safe as using condoms.** Prof Francois Venter, head of the Southern African HIV Clinicians' Society, said the trial involved over 1 700 couples, made up of an HIV-positive and HIV-negative partner. The HIV-positive partners had CD4 counts of between 350 and 500, meaning they did not yet need ARV treatment. Venter said that **people who were on**

successful ARV treatment were 100% safe and would not transmit the virus.

More firms offer cover for HIV-positive

SAPA-AFP, 1 December 2011

As people with HIV live longer, **South African life insurance providers are offering more policies** to tap into a growing market, but for many people the premiums are still too high. Insurance companies in like Old Mutual, Sanlam and Metropolitan Holdings offer HIV life coverage.

Malaria killed 655 000 last year

SAPA-AFP, 13 December 2011

Malaria caused the death of an estimated 655 000 people last year, with 86% of victims children aged under five, according to World Health Organisation figures. Africa accounted for 91% of deaths. To finance the fight, the WHO suggested a **tax on financial transactions or the rolling out of a tax on airline journeys** which it said, if extended to other countries, could generate significant extra funds. According to WHO other country-specific schemes, such as tourist taxes, might offer opportunities to raise funds for control programmes in malaria endemic countries.

3. DOCTORS, NURSES, HOSPITALS & TRAINING

Africa's R24bn doctor loss bill; First batch of clinical associates graduates

Reuters, 26 November; Business Day 9 December 20

A study by Canadian scientists found that SA and Zimbabwe suffered the **worst economic losses due to doctors emigrating, while Australia, Canada, Britain and the US benefited** the most from recruiting doctors trained abroad. Uganda spends $21 000, and **South Africa $59 000 to train a doctor**, only to see many of them migrate to richer countries. The findings suggested the **benefit to Britain was around $2,7bn,** and to the **US around $846m**. Australia was estimated to have benefited to the tune of $621m and **Canada was $384m** better off.

Meanwhile, the first cohort of s**tudents who completed the Bachelor of Clinical Medical practice degree graduated from Wits University**. They will enter the health service as part of a new cadre of **health professionals known as clinical associates**. They will work primarily at **district hospitals under the supervision of doctors** and provide medical services ranging from conducting routine patient consultations and performing common procedures, to providing emergency care for acute conditions and managing chronic diseases.

NHS doctors prescribe banker salaries

The Daily Telegraph via The Business Times, 27 November 2011

Figures published in England show that: **2,6% of partnered GPs in England earned more than £200 000 (R2,6m) in 2009/10;** the **average wage** for the 34 801 partner GPs in England in 2009/10 w**as £105 700 (R1,4-m).** The 7 267 salaried GPs - stethoscopes-for-hire who prefer to earn less and have fewer managerial responsibilities - earned about half that. Due to a 1996 scheme "quality outcome framework" (QOF) **government pays extra per target me**t – like taking blood pressure four times a year. For 2010/11, the average QOF payment/GP practice was £133000 (R1,7m).

Gauteng DoH accused of tender rigging; Cabinet shows its muscle; ANC defends health boss

SAPA, 29 November; The Star, 6 December; The Citizen, 6 December 2011

Government spokesman Jimmy Manyi said the cabinet had ordered that Gauteng Premier Nomvula Mokonyane to "**sign an agreement with the Minister of Health and the Minister of Finance to address financial management challenges in the Gauteng health department.**

The DA said the "takeover" by the Treasury of the health department was "an embarrassment to

the ANC provincial government". The cabinet also placed the **Free State's departments of finance, police, and roads and transport under administration.**
In November *The Star* reported that the Gauteng department of health **appointed contractors who did not have the correct qualifications** and competence to build hospitals. The department had awarded **three contracts worth R887m to a company that failed to submit a tax clearance certificate.** DA MP Jack Bloom was quoted as saying the AG's report **illustrated the department's "disastrous incompetence".** He said the distressing thing was that **nobody had been held accountable for the appalling mess. Nobody was fired or disciplined, so the mismanagement was likely to continue.**

Gauteng hospitals to manage own finances to avert crisis; No lifeboat for health suppliers
The Star, 7; City Press, 11 December 2011
Gauteng is handing financial control back to its four biggest hospitals to clean up the province's health department. The province is also **lobbying the National Treasury to take debts owed to Gauteng by other provinces or departments off the top of the defaulters' budgets to pay straight to Gauteng,** and **snipping 2 – 3% off each provincial department's budget** to pay the health debts. About R400m is expected to be released by the departments in April next year. **Gauteng must finance the clean-up of its ailing health department itself** as there is no national bailout. This emerged after the cabinet announced that it would intervene in Limpopo, Free State and Gauteng to sort out financial management. Part of the fix will see the province's academic hospitals - **Chris Hani-Baragwanath, Charlotte Maxeke, Steve Biko and Dr George Mukhari - running their own affairs by April.** The **Gauteng department of health owes its creditors R2,5bn in historical debt**. At the same time, the **department is itself owed R1,3bn,** much of it from government entities. About R700m is owed by the medicine depot.

Gauteng health department 'faces legal bid'
The Citizen, 12 December 2011
Suppliers are threatening to haul the Gauteng department of health before the courts to recover close on R375m in unpaid bills. Spokesman for the South African Medical Devices Industry Association (Samed), Tanya Vogt, said some of the smaller companies might go under and this would negatively affect patients in provincial hospitals.

Fraud cases opened on Gauteng health officials
Business Day, 7 December 2011
The Special Investigating Unit (SIU) had **opened fraud cases with the SAPS against a number of senior officials previously employed by the Gauteng department of health.** SIU spokeswoman Marika Muller said the unit was **investigating 11 contracts** awarded between January 2006 and May 2010, as well as the **irregular issuing of tenders, cases of alleged conflict of interest and fruitless and wasteful expenditure**. The list of officials the SIU had opened cases against included former department head Sybil Ngcobo and former deputy director-general Obakeng Mookeletsi.

New CEO for Hasa *(press Release, 7 December 2011)*
The Board of the Hospital Association of South Africa (HASA) has appointed **Dr Dumisani Bomela in the position of CEO**. HASA recently **restructured and realigned its strategy and brand** and the appointment of a CEO is integral to the realisation of the industry's vision of working with government to improve access and affordability to quality healthcare.

4. MEDICAL SCHEMES

Medical scheme members irate over hospital bills

Business Report, 6 December 2011

Disputes between medical aid members and their schemes over unpaid claims are now affecting the payment of in-hospital benefits and members are increasingly finding themselves liable for paying doctors' and specialists' bills. The **CMS received 5 617 complaints from scheme members in 2010**, some relating to schemes declining to pay members' accounts.

Costs key challenge for medical schemes in 2012

BusinessLIVE, 14 December 2011

The recent court ruling in favour of the Council of Medical Schemes (CMS) regarding the payment of Prescribed Minimum Benefits (PMBs) will remain one of the biggest challenges for the private healthcare industry in 2012, as schemes seek ways to contain medical scheme inflation and offset the risks of paying PMBs in full. According to Clayton Samsodien, managing director of Genesis Capital's healthcare subsidiary - Genesis Healthcare Consultants - schemes will need to identify clear Designated Service Providers (DSP) or Preferred Provider Networks (PPNs) in order to contain costs. The CMS is holding a meeting in January 2012 with regard to the proposed Risk Equalisation Fund (REF), a move that aims to equalise the risks in the private healthcare market by collecting funds from schemes to help subsidise those that have a higher risk pool of members. Many of the major schemes had indicated that paying PMB's in full would not affect their respective schemes. Medical schemes appeared to be in far healthier shape with the latest CMS Quarterly Report indicating that reserves were up by around 5,2% on 2010.

Another hot topic of debate is **Regulation 10 of the Medical Schemes Act which states that a member's personal medical savings account (PMSA) must be available for the exclusive benefit of the member.** CMS found that some schemes were not applying this regulation correctly in that the PMSA funds must be in a separate trust account to that of the medical schemes account. Schemes that are unable to comply must apply for exemption with CMS by January 2012.

Background: No structure for health fees now

Editorial comment: David Gleason: Business Day, 1 December 2011

The result of the action brought by the BHF against the CMS and 12 other respondents is that we are no further forward. The argument has its genesis in an **action taken by the commission** in 2003, when it **intervened in a long-established process** in terms of which medical aid societies and the South African Medical Association (Sama) **met to work out acceptable fee structures.** The commission concluded this was **anti-competitive** and said it would seek an order **prohibitin**g what it claimed was **price-fixing**. Since then there has been **no fee structure guideline**.

The second effect arrived when the **CMS said PMBs had to be paid by medical schemes in full**. The BHF said it wanted an order from the high court, adding that doctors' claims showed they charged more if the reimbursement rate provided by a medical scheme was higher. Some fixing needs to be done. **The place to begin is with the Competition Commission,** which is able to provide **"public policy" exemptions**.

Profmed bows to pressure over paying PMB claims in full; members pawns in payment battle;Profmed must pay for care

Personal Finance, 26 Nov; Business Report, 29 Nov;Business Report, 7 December 2011

The **CMS has threatened to deregister Profmed** (a restricted scheme for graduate professionals) which is contesting the regulator's interpretation of "pay in full". Profmed submitted to paying PMBS in full, but said it would **persist in its appeal against the regulator's demand that medical schemes must pay whatever healthcare providers charged to treat PMB** conditions. **The chief**

executive of the BHF, Humphrey Zokufa, said the fact that the board did not get an interpretation of "pay in full" from the court meant that the matter was not yet decided.
In the mean time Judge Justice Bam handed down judgment saying **Profmed must pay for in-hospital treatment as well as treatment after the member's discharge from hospital where continued post-hospitalisation treatment was clinically indicated**. He said he was not persuaded that the registrar of medical schemes and the CMS were wrong in ruling that the benefits provided for in terms of rule 1E4 extended beyond in-hospital treatment. **The ruling comes** as Profmed faces deregistration threats from the CMS for its non compliance with PMB regulation.

Judgment could force some medical schemes to close savings accounts
Personal Finance, 26 November 2011
Medical scheme trustees may be forced to **reconsider offering medical savings accounts, or to limit upfront access to the contributions made to the account during the year.** The BHF has warned this may be a result of the **regulator's instruction to schemes to ensure that, by January 1 next year, all medical savings account money is in a trust account separate from a scheme's bank account.** Separating savings account and scheme funds could affect schemes' reserve.

5. PHARMACEUTICALS

Litha Healthcare in deal with Indian manufacturer
BusinessLIVE, 13 December 2011
JSE-listed Litha Healthcare Group Limited has announced the signing of an exclusive agreement with **Gland Pharma Limited**, a leading Indian-based generic pharmaceutical manufacturer which boasts world class facilities for small volume parenterals (SVPs).

Medical aids pass on drug costs
Business Report, 30 November 2011
The regulation of the single exit price (**SEP) of drugs has caused the country's medicine prices to drop. However, medical aid members** are increasingly **paying for medicines from their own pockets or medical savings accounts**. M**embers now pay for medicines more than for any other healthcare intervention**. Of the payments made from beneficiaries' savings accounts, medicines accounted for 34,2%. On the other hand, payments made from medical schemes' risk pools for medicines accounted for only 14,7%.

6. FINANCIAL NEWS

Tax credits may make it cheaper to belong to a medical scheme; Tax credit plan 'progressive'
Personal Finance, 26 November ; Business Report, 12 December 2011
Tax subsidies for medical scheme contributions are due to change from March next year. For taxpayers **under the age of 65, the subsidy will change from a tax deduction** (an amount set off against taxable income) **to a tax credit** (an amount set off against the tax that must paid), at a rate that is expected to make **medical scheme membership more affordable for lower-income earners**. People who **earn more than about R325 000** a year could end up paying **more ta**x when the tax credit becomes effective. People who **earn less than about R235 000** a year should see some kind of t**ax saving**. The change should be largely neutral for people who earn annual amounts between R235 000 and R325 000. **Taxpayers over the age of 65 will still be able to deduct from their taxable income** all their medical scheme contributions, as well as all their medical expenses.

According to health analysts the conversion of medical tax rebates to tax credits could be a **game changer for the country's health system and will benefit lower-income individuals who belong to medical aid schemes.** Econex chief economist Cobus Venter said the idea was that it should not be proportional to one's income anymore, but was a flat amount and from an economic point of view was a lot more progressive. If anything, it would encourage people who could not afford medical aid - but had to pay 100% at public hospitals - to join a medical aid.

7. GENERAL NEWS

Revolutionary hip-replacement carried out at SA hospital

The Star, 29 November 2011

A Tshwane surgeon has performed the **first-ever hip-replacement surgery using a bearing made of zirconium, a metal specially developed to prolong the lifespan of artificial hips**. Dr Charl Olivier, who performed the surgery, said that about 80% of traditional artificial hips need to be replaced after 15 years as they wore out, but it was hoped that this technology would last a lifetime. The technology was still at an experimental stage.

Health 'first casualty' of climate change

Business Day, 5 December 2011

According to the Lancet medical journal, **climate change is the greatest global health threat of the 21st century**, and changing climate conditions will lead to **increases in malaria, cholera and dengue fever, as well as losses of life due to extreme weather events.**

One in five workers 'has a mental illness'

Reuters via Business Day, 13 December 2011

Research has found one in five workers suffer from a mental illness such as **depression or anxiety and these conditions increasingly affect productivity in the workplace** as many struggle to cope. The World Health Organisation predicts that by **2020 it will be the second leading contributor to the burden of disease across the globe and across all ages**. Between 30% and 50% of all new disability benefit claims in OECD nations are now due to poor mental health. People with mental illness were more likely to be unemployed as people with no mental health problems.

ADDENDUM:

A summary of A supplement to Business Report (1 December 2011)
SPECIAL PROJECTS: Rating the Medical Aid Administrators

Loraine Tulleken: Business Report, 1 December 2011

In the complex medical schemes industry few are truly customer centric

"Each customer experience must be measured, optimised and continuously improved in order to achieve customer centric, quality service delivery. It's here that a **quality standard such as ISO 9001:2008 can help in instilling this discipline,"says** Kevin Aron, Managing Director of Medscheme South Africa.

As administrators can provide services to more than one medical scheme **the pressure is on employees of the administrator to deliver a positive experience to customers who may not even realise that they are interacting with a separate company,** says Aron.

Sustainable healthcare delivery is all about the smarter use of resources and achieving greater efficiency.

Training is also a keyword. Call centre teams should be well trained, competent and supported by excellent technology and business processes.

"A customer centric approach places the customer at the centre of the organisation and becomes the platform from which the entire business operates. A company's ability to deliver an experience that sets it apart in the eyes of its customers serves to inspire **loyalty to its brand**. Loyalty is **driven by a company's interaction with its customers** and how well it delivers on their needs as well as their wants," he states.

Private sector urges use of its expertise

Various players in the private healthcare sector are urging Minister Aaron Motsoaledi to **use private sector administrators to manage the NHI**. They include the Hospital Association of SA (HASA) and the Metropolitan Health Group.

The latter's CEO, Blum Khan, offers a **model that draws on the strengths of the public and private healthcare sectors and substantially reduces their weaknesses.**

These are its six key features:

1. **NHI must be a partnership between the private and public health sector**
2. **All SA residents will contribute**

   All working South Africans (and foreigners on permits) should contribute between **1,75% and 2,5% of their taxable income to NHI** with their **employers contributing** an equal additional proportion. Together, these contributions would fund a network of NHI hospitals to which any contributing South African could go.

   The unemployed also has to be catered for; perhaps through a hospital in each area being specifically set aside for "indigent" citizens. In every region, South Africans would be able to **choose between NHI, indigent and private hospitals.**
3. **Private healthcare clients**

   Everybody with a job will be required to pay the NHI levy, along with their employer. Those **who want private medical care will inevitably end up paying more** both as a result of the new levy and to make up for the end of the state subsidy. On the upside, those South Africans who want to continue to benefit from high quality private healthcare, will be able to do so.
4. **Hospitals should be run by private contractors**

   Three or four hospitals in each major metropolitan area, for example, should be designated as NHI hospitals and anyone who contributes to NHI can opt to be treated at these hospitals. The difference is that the operation and **administration of these hospitals should be put out to tender** and should be run by experienced, in some cases foreign, private sector companies.

   Back-office administration should also be tendered out to crack down on corruption and false claims, but there should be agreement that at the end of the 15 to 20 year period**, a state agency should be established with the current personnel, skills and equipment**. Taking a large number of hospitals off the state's books for a period of 20 years should result in the saving of tens of millions of rand.
5. **Licensing needs to change**

   Doctors in rural areas should be paid more than doctors in the cities and should enjoy greater benefits and perks.

   All private sector GPs should be brought into the loop as NHI providers. They will need to buy in to the tariff rates and conform to the clinical protocols and guidelines set by NHI.

   The manner in which **licenses** are held to operate in the industry will also have to be **reviewed and reissue or issue additional licenses to enable more competitio**n to prevail in the industry.

6. The private healthcare sector

The private healthcare system will undergo fairly **serious restructuring and change**. This may lead to **the collapse of several medical schemes and consolidation in the industry**. The inclusion of private sector skills, facilities and administrators in a new NHI network will offer new opportunities and possibilities.

Innovation and agility are keys to survival

Agility and a forward-thinking approach are required to successfully respond to new developments within the South African healthcare funding environment, according to Grant Newton, CEO of Sanlam Health**. Advanced administrative capabilities and superior service levels have become absolute business essentials.**

Newton says there is **increased industry demand for integrated and customer-centric systems**. Sanlam Health is one of a few South African medical scheme administrators to **operate an independent IT platform**. The ISO 9002 compliant iMed system was first rolled out as a fully integrated system to further enhance the flexibility of Sanlam Health's information management capabilities. "**iMed has since evolved as a fully integrated, automated web-based transaction engine for real time processing and interaction with members, including assessment of claims, processing and calculation of member benefits, pre-authorisation and risk management administration**," Newton explains.

Current iMed clients include Resolution Health, the Rand Water Medical Scheme and the Associated Fund Administrators in Botswana. The system currently supports in excess of 4,5 million members across all markets.

BHF warns that schemes and members could be fleeced

The BHF is calling for the Minister of Health to stem the tide which could see some medical schemes and their members being "fleeced of their funds".

It views the recent announcement by the Registrar for Medical schemes, **to de-register a medical scheme based on its refusal to pay for PMBs in full, with great concern.**

"The Registrar's insistence that medical schemes pay the full cost of what a healthcare provider charges, no matter what that cost is, will **negatively affect the consumer**, and even make medical scheme membership unaffordable

"**This is because there is no regulated process on how those who provide healthcare services should charge**. The funds of a medical scheme, which are made up of member contributions, are looked after by a board of trustees who must ensure that they are used responsibly. By enforcing a **'pay in full at whatever cost' rule the Registrar is creating an "open-ended liability for the scheme and an open cheque for the healthcare provider".**

The registrar's interpretation that the High Court's ruling in November that PMB-conditions listed in the Medical Schemes Act 'must be paid in full' is erroneous as Judge Cathy Pretorius **dismissed the case on a legal technicality and therefore did not rule on the merits and principles of the matter.** The BHF argues that the actions by the Registrar and the current behaviour by some providers **simply reinforce the need to regulate costs relating to healthcare services.**

Holistic administration solutions the way forward

Medical schemes are increasingly looking for **administrators that are able to offer holistic and flexible administration solutions able to cope with and adapt to the continued onslaught of local legislative changes.**

Managed Care Executive, Dr Tumi Seane, pointed out an internationally acclaimed Epic system. **It has been customised to meet the needs of the complex SA healthcare environment,** and **provides healthcare software solutions for more than 100m lives worldwide.** "The system is designed to manage integrated delivery systems, like care organisations, medical groups and hospitals with

large ambulatory care environments. It has the capacity to adapt for capitation system, and conversion capabilities to a fee-for service," says Seane. Technology and people skills are key focus areas in order to offer members the benefit of a state-of-the-art IT system and streamlined call centre structures to improve service.

Welcome signals re NHI

Dr Humphrey Zokufa, managing director of the BHF, says: "If the existing 99 medical schemes with a total of 8,2m members and the 20 scheme administrators can **become a template for NHI, then ordinary members will not feel the effects of the move to the national scheme**. It will be a seamless move into a bigger risk pool with the benefits that come with that."

Utilising the skills that are used to run existing medical schemes to administer NHI will mitigate the risk of such a large fund being run by people who have never run such a fund before, he adds.

According to Zofuka members will **not be forced to pay contributions to the NHI Fund until there is greater clarity on how the system will work and it has "some traction**". Only at that stage will the tax deductions be removed, he says. He acknowledges that once NHI contributions become compulsory it may be difficult for most working South Africans to pay another contribution to a medical scheme.