SUMMARY: HEALTH NEWS HIGHLIGHTS: APRIL 2012

Introduction:

Financing of universal healthcare coverage is not beyond the reach of SA, as currently **funds are available within the system**. This was the **consensus among members of the World Bank, the World Health Organisation and leading health economists at a recent NHI conference: Lessons for South Africa.** However, in an article in *The Saturday Star, 7 April 2012* Prof Ames Dhai , Director of the Steve Biko Centre for Bioethics at Wits*,* says what is **urgently required is the efficient management and use of the funds coupled with the elimination of corruption.** The question is **not whether NHI should be implemented**, but **how this should be done and what method of financing would be the most fair**. "Although the trajectory is going to be long and challenging, it will be worth it for the future of our country and its people," says Dhai. (p3)

However, in a comparison by Innovative Medicines SA (IMSA) (before introducing the controls mentioned above) it found on average, that **private hospitals were 1 438 times more expensive than public hospitals**. However, after **equating like for like**, it found that **private hospital costs were 1 053 times that of public hospital costs. (**Read more on this on p10: *Doctoring figures of healthcare)*

"What South Africa **does not have, is the human capital** - doctors, nurses or medical specialists - to meet the needs required for the **successful implementation of the NHI**," says **Graham Anderson**, principal officer at Profmed, medical scheme for graduate professionals. However, SA has a **reasonably affordable, well-run private healthcare system** that can assist in the introduction of NHI, he concludes. (p1, 2)

Prof Gavin Mooney, CEO of Africa at Work, a consulting company focusing on African business, suggests in an article in *The Saturday Star, 7 April*, that we "**start with one of the big teaching hospitals and bring that up to speed in terms of quality of care, efficient management and management systems to act as a major demonstration project** showing just what the public sector is capable of". (p3)

"If political leaders, who influence policy and funding choices, were forced to use public health systems, they would find a way to address many of the challenges they blame for the condition of systems that force them to flee to other countries when they feel a bit poorly," he concludes. (p4)

That a U-turn is indeed possible as far as the unbearable conditions of public hospitals are concerned, was demonstrated by Dr Naing Soe, acting CEO of the **Tshwane District Hospital**, who has been lauded for **turning the ailing facility into a "humane place".** All it takes is a bit of "human **common sense and a caring attitude** ", says Soe., who took over in March 2010 and managed to **save R8-m in two years**, which he **reinvested in the hospital's refurbishment** and **buying new equipment.** (p6)

*Doctoring figures of healthcare Editorial Comment by: Garth Zietsman**, The Star, 17 April 2012*

SUMMARY OF HEALTH NEWS: APRIL 2012

INDEX

1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

White Paper on NHI imminent
Business Report, 24 April 2012
South Africa **does not have the human capital** - doctors, nurses or medical specialists - to meet the needs required for the **successful implementation of the NHI**. The reality is that the **scale of the project is so vast it will be impossible to have it completed in the next 14 years**, according to **Graham Anderson**, principal officer at Profmed, medical scheme for graduate professionals.

Government's **White Paper** on the NHI initiative is expected to be published imminently, **providing more detail on exactly how the project will be implemented.** Most likely the **current public healthcare system would simply be improved over the next 10 to 15 years, providing the desperately needed better healthcare to the lower income population, says Anderson.** He added that it was **unlikely that the country would be able to afford a universal healthcare system within the planned timeframe as the proposal currently stood. If state hospitals could at least be taken out of disrepair it** would provide a good starting point. SA has a **reasonably affordable, well-run private healthcare system** that can assist in the introduction of NHI. **In a submission to the government**, he added, the **Board of Healthcare Funders** had offered to **provide resources from the private sector**. In **fixing the healthcare system;** it would be crucial to have **all stakeholders** buy into the process and work together to achieve a common goal, he said.

NHI stillborn without doctors
The Times, 17 April 2012
The South African Medical Association (Sama) singled out **doctor shortages as "one of the major issues" standing in the way of the multibillion-rand NHI scheme.** The non-statutory association, which has a membership of 17 770 doctors, said the **number of graduates (1 200) produced each year by 8 medical schools would need to be doubled for the next 10 years for the country to have enough doctors**. In addition, Government would have to **introduce incentives to retain highly skilled medical practitioners and speed up the registration of foreign doctors seeking employment in SA**. In 2011 Wits University spent R8-m to enrol a further 40 medical students, and the other 7 medical schools would be given R48-m to take 160 more students for this financial year. - 100 doctors would receive management training at Sama's expense. **Doctors in private practice were willing** to heed Dr Motsoaledi's call to work four hours a week in public facilities, but **were concerned about compensation**.

NHI Pilot Project: Back to basics together; City set for NHI rollout
The Financial Mail, 13 April; SAPA, 22 April 2012
Although Health Minister Motsoaledi has had **harsh words for the private sector** in the past, he realises that its **help will be crucial to the success of the NHI and the pilot scheme**. Private practitioners will be asked to make time available to work in public clinics. Motsoaledi has also **met the CEOs of 16 private health companies**. The private sector could also help in tackling the combined disease burden of **TB and HIV/AIDS; assistance with human resources; training of hospital managers, specialists and nurses; and** the sponsorship of specialists. The pilot project will also focus on **improving the values and attitudes of staff, managers and patients; reducing waiting times; keeping patients safe; providing reliable care; and, ensuring medicine and equipment supplies.** As part of the NHI rollout Motsoaledi **wants all SA's health institutions to make submissions on infrastructure development and provide equipment logs.**

More news on the pilot project is that **Gauteng health MEC Ntombi Mekgwe**, says **Tshwane is ready to roll**. The first phase would include **several clinics** (combined population of 848 199; 31% of the Tshwane district). A **quality assurance unit** and a **provincial office of standards compliance** have been set up and the department was also appointing "**district clinical specialist support teams**". Each team comprises of an obstetrician, a family physician, a paediatrician, an anaesthetist, an advanced midwife, a clinically trained nurse and a paediatric nurse. The **department was also clearing all debts to suppliers and service providers.** As things stood currently, 2 604 suppliers were each owed less than R1-m.

Exploring the sharing of healthcare resources
Editorial comment: *Ames Dhai*: The Saturday Star, 7 April 2012*
At a recent NHI Conference: *Lessons for South Africa*, views expressed by members of the World Bank, the WHO and leading health economists in the country were that the **financing of universal coverage is not beyond the reach of SA**, as currently **funds are available within the system**. However, what is **urgently required is the efficient management and use of the funds coupled with the elimination of corruption.** The indicator of the success of the NHI will be the **achievement of universal coverage**. The question is **not whether NHI should be implemented**, but **how this should be done and what method of financing would be the most fair**. Trade-offs will be inevitable. Although the trajectory is going to **be long and challenging, it will be worth** the future of our country and its people.

***Professor Ames Dhai is the Director of the Steve Biko Centre for Bioethics at the University of the Witwatersrand**
In another article on NHI, ***Something is rotten in SA hospitals… NHI will fix it,*** published in *The Saturday Star, 7 April 2012*, Prof Gavin Mooney* suggests that South Africa "**start with one of the big teaching hospitals and bring that up to speed in terms of quality of care and efficient management and management systems to act as a major demonstration project** showing just what the public sector is capable of". To do this **under the banner of the planned pilot studie**s would be **money well spen**t. The **private sector** also lacks efficiency. **Quality of care is higher, but all too expensive**. On the ethical issues, he says: "What currently exists in SA healthcare is **obscene. M**ore obscene, however, are the **efforts from some quarters to try to defend the status quo**. **Fairness must be the watchword** in future SA healthcare."
***Gavin Mooney is Professor of Health Economics at the University of Sydney and an Honorary Professor at the University of Cape Town**

Fighting corruption to achieve Millennium Development Goals (MDGS)
Summary of Article by CGF Research Institute; 13 March 2012
Crime experts, economists and NGOs were recently not surprised that an estimated R30-bn was being lost annually by South African taxpayers due to graft, incompetence and negligence in the public service.

Research by TFAC (The Fight against Corruption), found that **600 000 new low cost houses**, **60 hospitals with a 280 bed capacity each, 3 000 rural clinics and 915 new schools could be built with the R30-bn estimated to have been misappropriated from state coffers.**

In order for African countries to achieve their **primary MDG goals; to halve poverty, reduce child mortality by two thirds and achieve universal access to primary education by 2015, at least 7% year-on-year GDP is required.** Before SA can realistically address its MDGs, it will need to address the **bankruptcy of some of its provinces and municipalities** which has been caused mostly **through corruption, maladministration, tenderpreneurship, nepotism and cronyism**. "We must remain cautious about believing that the MDGs can be achieved through development aid alone." The fight against corruption, particularly supported by the Cosatu general secretary Zwelinzima Vavi, is beginning to find greater support not only from Government, but also from the millions of poor people who suffer as a result of it. According to **Vavi corruption has become the biggest threat to the realisation of South Africa's dreams;** almost 20% of government procurement is currently lost to corruption as officials exploit gaps in the system and are awarded government tenders. Revenue Services, have launched the lifestyle audits, as well as the anti-corruption task teams established by Pres Jacob Zuma, including the Corruption Watch initiatives (allowing ordinary citizens to report graft). Signs of improvement are definitely visible. From September 2004 to June 2011, the **National Anti-Corruption Forum formally charged over 1 273 public service officials with misconduct for** corrupt activities. A powerful message is being sent that corruption is one of government's top priorities, **as 603 officials have been dismissed from public service, 226 suspended, 134 fined and 16 demoted.** As this example is set, millions of impoverished people - dependent on the positive progress of the MDGs - will begin to experience a nation who embrace humanness, where pride and dignity can be restored in all its people. For more info: www.cgf.co.za or www.corporate-governance.co.za

Unhealthy burden; State offers clarity on health insurance rules; Treasury invites comments
Michael Settas*: *The Financial Mail, 13 April; Business Day, 17 April; SAPA, 17 April 2012*
Private healthcare costs in SA have grown far beyond CPI levels for more than the past decade.

The **primary architect** of the new regulations has been the **Council for Medical Scheme**s, which appears to have **convinced Treasury** that if **gap cover** products are allowed to continue, they will **prevent the young and healthy from joining medical schemes**, and thus destabilise them. However, **the very missing pillar of mandatory cover is keeping the young and healthy out of the system, rendering it unsustainable.** The department would do well to revise this **inherently dysfunctional structur**e, which is inflicting immense pain upon its own constituency, rather than playing the blame game where the only loser is the consumer.

***Settas is MD of Xelus Specialised Insurance Solutions**
Meanwhile the Treasury and the Department of Health have issued a joint statement to "**clarify potential misunderstandings**" regarding the proposed **regulations for demarcating health insurance** products. They said the draft regulations **propose phasing out only those health insurance products that "compromise the key principles of social welfare, solidarity and cross-subsidisation found in medical aid schemes", such as gap cover and top-up cover products.**

The Treasury said the public ought to know **medical schemes and health insurance products were different**. **Anyone could buy a short- or long-term health insurance policy,** the premium depending on the insurer's assessment of one's health status. Medical schemes are **not allowed to discriminate against a member** on any grounds, including **age and health status**. **Health insurance** products usually provide **limited cover**.

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

SA health strategy hailed; MCC asked to give TB drug the green light; Life-saving drug on hold
Health-e News Service, 17 April; The Times, 30 April 2012
South Africa has been **hailed for its forward thinking in launching the NHI**, which will **for the first time include treatment of TB alongside HIV. All people infected with TB will be treated with ARVs, regardless of their CD4 coun**t, in line with WHO recommendations. Fareed Abdullah, CEO of the SA National AIDS Council, which will monitor the plan's implementation, called the plan's targets "ambitious but achievable".

However, earlier this month, in a letter to the Medicines Control Council (MCC) and Health Minister Aaron Motsoaledi, Médecins sans Frontières, 50 doctors and scientists asked for **"compassionate use"** of a new drug. **The latest news** is that **the MCC has decided that Bedaquiline** will be **withheld until all clinical trials are completed. The drug** has the potential to save the lives of those suffering from the **most drug-resistant form of TB**, commonly known as XDR-TB. The council says it has concerns about the drug's long-term effects and how it will be monitored.

Couples should test together; Free circumcisions to fight HIV; ART patients exceeding targets
SAPA, 17 April; Health-e News Service, 23 April; Health-e News Service, 25 April 2012
New **international HIV-testing guidelines** are encouraging **couples to be tested together** and urging the **immediate initiation of antiretroviral therapy** for a person testing positive with the virus. The World Health Organisation (WHO) has recommended that a person with HIV (who has an HIV-negative partner) be offered HIV treatment.

Meanwhile 125 000 free male circumcisions will be performed by a non-profit HIV and AIDS organisation **Right to Care** in the next 18 months in order to **curb the spread of HIV**. According to Right to Care circumcising men could reduce the risk of HIV infection and cervical cancer. The initiative will be supported by the United States Agency for International Development (USAid) and will receive funding from the US President's Emergency Plan for AIDS Relief.
According to an article by Dr Leigh Johnson (UCT) in *The Southern African Journal*, the number of **patients receiving ART in SA by the middle of last year had increased to 1,79-m from less than 50 000 in 2004.** This was well **in excess of the 80% target of patients who were eligible for ART**. Johnson's research revealed that the majority (61%) of patients were women aged 15 or older; men accounted for 31%; and children below the age of 15 8 %.

AIDS offers Africa a stimulus, too
The Business Times, 8 April 2012
Africa should **stop seeing AIDS as just a burden** - and instead use it as an **opportunity to establish a viable pharmaceutical industry,** according to UNAIDS executive director Michel Sidibè. Although Africa was home to 90% of the people on AIDS treatment, **most of the drugs came from outside the continent**. The fight against HIV/AIDS could be used to create a **new industrial platform for the continent, he said. Sidibè** urged African governments to **engage with global and domestic partners** to finance the project.

AIDS testing goes hi-tech
SAPA-AP, 10 April 2012
In Mozambique **getting AIDS test results from labs to remote villages** once took weeks. Now, communications engineers from Britain's Sequoia Technology Group and Telit Wireless have **adapted office printers and cell phone technology to wirelessly** and immediately relay test results. The technology is available at four laboratories in Mozambique. In the first six months the programme was up and running and 20 000 results were relayed to the printers. It is **reliable, and cheaper than sending a cell phone text message**. Botswana, Kenya, Tanzania, Uganda and Zimbabwe will be next.

3. DOCTORS, NURSES, HOSPITALS & TRAINING

Africa's hospitals crumble while leaders are treated elsewhere
Business Day, 23 April 2012
The **death of Malawi's president Bingu wa Mutharika in a private clinic in Johannesburg** brings to mind **other African leaders whose lives ended in hospitals far from their home countries**. Most of the continent's current leaders prefer to be sick in foreign hospitals and private clinics. But **most Africans cannot afford private healthcare facilities** and don't have access to **medical insurance**. Even public healthcare is seldom entirely free for patients, says Me Dianna Games, CEO of Africa At Work, a consulting company focusing on African business. **Poor management** systems, a **lack of maintenance** and **hygiene** in facilities, **poor municipal services, inadequate equipment** and **fraud in tendering** and procurement processes deter progress. Two issues seem to be clear: **Government funding is well below what is needed to sustain a basic healthcare system** and **what exists is not being used efficiently**.

If political leaders, who influence policy and funding choices, were forced to use public health systems, they would find a way to address many of the challenges they blame for the condition of systems that force them to flee to other countries when they feel a bit poorly, says Games.

Ailing hospital saved
The Times, 12 April 2012
All it takes to turn a hospital around and get it ready for the NHI scheme is a bit of "**human common sense and a caring attitude** ", says Dr Naing Soe, acting CEO of the **Tshwane District Hospital**, who has been lauded for **turning the ailing facility into a "humane place".** Soe took over in March 2010 and managed to **save R8-m in two years**, which he **reinvested in the hospital's refurbishment** and **buying new equipment.** Department of Health spokesman Fidel Hadebe said Soe was "a shining example of how things can be turned around by good management". Soe, who is from Burma, first came to South Africa in 1995 and worked at Pretoria West Hospital. Tshwane is one of the 11 areas recently identified for the NHI pilot project.

Where patients sleep on floor; 'Medical staff; a victim of bullying'
The Cape Argus, 4 April; 2 April 2012
In the *HealthMan's* March summary, we reported on **the efficient Western Cape healthcare system**. However, since then a **senior Cape Town doctor has lifted the lid on conditions at the city's Eerste River Hospital**. The doctor, the former head of the hospital's trauma unit who spoke on condition of anonymity, said **doctors and nurses at the hospital felt trapped and were being bullied by managers**. He also **provided a range of pictures to corroborate** his story. But Faiza Steyn, spokeswoman for the provincial Department of Health, said the **allegations were untrue**, and the **doctor had been dismissed** after he was **irregularly appointed**. Damaris Kiewiets, head of the Cape Metropolitan Health Forum, said firing a doctor after he allegedly asked questions about clinical governance at the hospital **was just the tip of the iceberg**. Apparently **many doctors and nurse managers had either lost their jobs or had been shuffled around** within the department after **they raised grievances** about clinical governance or service delivery. **Faiza Steyn denied allegations** that the department was "victimising" its staff.

Medical lawsuits plague Gauteng; SA doctors incensed by 'ambulance chasing' campaign
SAPA, 16 April; Mail & Guardian, 17 April; SAPA, 16 April 2012
HPCSA's campaign calling on members of the public who are unsatisfied with the healthcare they have received to **lodge complaints with the council**, has received strong reaction from Sama. Acting CEO, Dr Mark Sonderup, **likened the campaign to "ambulance-chasing" lawyers** who tout for aggrieved parties to file lawsuits, saying it was outside HPCSA's mandate. He said the **mandate was to protect the public and to drive the medical profession**. The HPCSA received more than 10 000

complaints against medical practitioners in the last four years; about 250 doctors had been fined; 151 suspended; and 18 struck off the roll. Offences included **overcharging or charging for services not rendered**; **insufficient care** or **mismanagement of patients**; **sexual misconduct**; and **negligence.** But Sonderup said there had been an "unfortunate misrepresentation" of the situation.

Meanwhile DA MP Jack Bloom has said **higher payouts for medical negligence cases will severely affect the Gauteng Health Department's budget**. Recently Gauteng premier Nomvula Mokonyane has been ordered by the court to pay R12-m in yet another medical negligence case. The department had already paid **R15,5-m in two medical negligence cases this year.**

4. MEDICAL SCHEMES

Outlawing gap cover won't aid medical schemes, members
BusinessLIVE, 26 April 2012
Draft legislation released recently by National Treasury will, if implemented, **outlaw gap cover and mostly likely lead to a simple loss of benefits for members,** without helping medical schemes. According to Ken Schumann, Consulting Actuary at Old Mutual Corporate, the legislation to ban gap cover was **intended to promote cross-subsidisation** among members of medical schemes by **forcing healthier members who wanted better medical cover to join more comprehensive options** instead of taking out gap cover. According to Schumann**, gap cover allows for cross-subsidy between healthy and unhealthy members.** This kept contributions low and ensured that even healthy people, who were not expecting to claim, did not mind paying the relatively low gap cover premiums. On the other hand, **medical schemes were not permitted to have cross-subsidies between different options**, and top options were usually expensive.

Medical aid schemes 'fuelling inflation'
Business Day, 17 April 2012
The South African Medical Association **(Sama)** accused **medical aid schemes of driving medical inflation**, saying **overspending on administration and broker fees** was pushing up costs, **not doctors' fees.** Figures provided by Sama show **non-healthcare costs accounted for 13,1%** of medical schemes' risk pool expenditure in 2010, while **general practitioners and specialists got 5,5%** and **19,5%** of the pie respectively. Schemes spent R88-bn from their risk pools in 2010, according to Sama's analysis. Describing non-healthcare expenditure, which includes administration, broker fees and managed healthcare programmes as "quite staggering", acting Sama chairman, Mark Sonderup, said. **Heidi Kruger,** spokeswoman for the Board of Healthcare Funders (BHF), said attributing the private sector's cost spiral to **medical schemes' non-healthcare expenditure was a "red herring".**

Bestmed and Sanlam cut ties
The Financial Mail, 27 April 2012
Bestmed Medical Scheme and **Sanlam Health** (SMH) have decided on an amicable **end to their relationship.** SMH CEO Grant Newton said pending approval by the Competition Commission, SMH would sell Bestmed back its administration business. Newton said the companies had jointly decided to pursue their own interests as they differed on the strategic positioning of both companies.

Old law challenged
The Financial Mail, 13 April 2012
According to the regulator and common law a **medical scheme may request repayment of medical expenses recovered from a Road Accident Fund** (RAF) claim. But the SA Association of Personal Injury Lawyers (Saapil) is planning to **challenge this assertion**, which is upheld by the RAF, the Council for Medical Schemes (CMS) and SA law. Saapil president Ronald Bobroff said the **implications of a member's liability to reimburse schemes were not common knowledge** - unlike public awareness of

RAF compensation paid for through the 80c/ l fuel levy. Bobroff said with an annual 72 000 road injuries and 15 000 people killed in road accidents, **risk should be included in schemes' monthly premiums**. The CMS said **medical schemes were obliged to pay for members involved in a road accident.** When members **successfully claimed from the RAF**, that portion paid up-front by the **medical scheme must be refunded** to the scheme. It said schemes reserved the claim under the common law of subrogation - the law of substitution - and believed **failing to pay a scheme the RAF compensation** amounted to **"unjust enrichment"** or double compensation for the same health event. CMS registrar Dr Monwabisi Gantsho says **schemes were obliged to pay for a member involved in an emergency event** as a PMB and the RAF was the primary insurer of road accidents.

5. PHARMACEUTICALS

Drug firms welcome move for African standards
Business Day, 30 April 2012
Pharmaceutical companies have welcomed news that the **East African Community regional bloc** has launched a project **to harmonise medicine regulation within the region**, a development they hope will add impetus to a similar initiative in Southern Africa. One of the biggest impediments to pharmaceutical companies doing business in Africa is **the time it takes to register their products in different countries**, says Vicki St Quintin, CEO with the Pharmaceutical Industry Association of SA. The countries involved in the project **are Kenya, Tanzania, Uganda, Rwanda and Burundi**.

J&J must pay $1,1-bn penalty in Risperdal case
Bloomberg, 12 April 2012
Johnson & Johnson has been ordered to **pay more than $1,1-bn** by a judge after an Arkansas jury found the company's officials **misled doctors and patients about the risks of the antipsychotic drug Risperdal**. J&J and its Janssen unit committed more than **238 000 violations of the state's Medicaid fraud laws** by **illegally marketing Risperdal** over an almost four-year period. The drug company has to pay **$11,4-m in penalties on the trade practices violations**. The state had sought more than $1,2-bn. J&J's Janssen says it will appeal, should a motion for a new trial be denied. The penalty amounts to **11% of J&J's $9,7-bn in net income** for 2011.

Drug importers fear local content; State tender to boost SA pharmaceutical production
Business Day, 10 April; Business Day with SAPA, 16 April 2012
Department of Trade and Industry measures (announced by dr. Rob Davies) aimed at **reviving the waning pharmaceuticals production sector,** includes the **issuing of a tender valued at R2,5-bn for two years of local procurement of oral pharmaceuticals**. The tender would require that at least **70% of the procurement should come from local** manufacturers. The remaining 30% would be on an open tender but could go to local manufacturers as well. A **reference pricing model** was being drawn up in conjunction with the Department of Health. Earlier the **National Association of Pharmaceutical Manufacturers** complained it had **been sidelined by the** government as it drew up plans for new regulations. Its complaint, (flatly denied by the department) **highlighted how high the stakes were for small importers of medicines.**

Drug firms upbeat on local sourcing rule; Sanofi in state deal to produce drugs locally
Business Report, 17 April; Business Day, 3 April 2012
The **newly announced preferential procurement regulations for pharmaceuticals** will **encourage multinational drug firms to invest in local manufacturing plants**, a move that is expected to improve South Africa's trade balance. According to the **third Industrial Policy Action Plan, 70% -80% of Government's procurement of pharmaceuticals** should be **sourced locally** by 2015. The aim is **to stimulate the domestic industry and attract foreign investment, create jobs and ensure sustainability of medicine supplies**. **Aspen**'s head of strategic trade, Stavros Nicolaou, said a number

of **multinational firms had begun to invest in local plants**.

Meanwhile pharmaceutical manufacturer **Sanofi has signed a technology transfer agreement with the Biovac Institute** (owned by Litha Healthcare) to **enable the local manufacture of a six-in-one infant vaccine,** and clinched a **deal with Indian firm Hetero** to import active ingredients used to make AIDS drugs. The deal would **enable the local production of AIDS drugs** at Sanofi's plant in Mamelodi.

The state of play
The Financial Mail, 13 April 2012
The IMS Health Global Pharma Prognosis estimates that **SA will account for 23% of African pharmaceutical sales by 2014**.

Aspen has the **strongest product pipeline** among the four local companies. Aspen also **reduced its exposure to the SA market at the right time.**

Adcock, however, has its major operations in SA. It also had to deal with the dextropropoxyphene (DPP) **painkiller banning issue**, but was exhibiting a **strong performance in the over-the-counter (OTC) segment**.

Cipla's performance was much stronger and it **remained the fastest-growing of the four**.
Litha Healthcare is also expanding rapidly. It made **two pharmaceutical acquisitions** and there is a **pending Pharmaplan acquisition.**

Extensive chronic medications headache; chronic medication delivery delayed in Western Cape; Prescription service on track
SAPA, 4 April; Fin24, 1 April; Business Day, 20 April 2012
According to Investec Asset Management portfolio manager Neil Stuart-Findlay, much of the pharmaceutical industry has been affected by the **regulations on single-exit pricing,** in terms of which the **Minister of Health determines price increases on certain products each year**. **Prices were not increased last year** and for this year an **increase of just over 2%** was permitted. Industry players had had **little scope to raise prices** last year, while operating costs such as wages and electricity had continued to go up. The consumer environment had also been more difficult with regard to **over-the-counter products,** with consumers buying fewer or cheaper items.

Meanwhile Western Cape health MEC Theuns Botha says the **repeat prescription services were back to normal for Cape Town's chronically ill patients**, after a bumpy ride and technical problems in the handing over of chronic medicine delivery service from Institutional Pharmacy Management (IPM) to UTI Pharma. The **service** might be **expanded to the entire province** within the next five years, reaching half-a-million patients. Meanwhile **Gauteng and KwaZulu-Natal** are **considering similar services** in order to reduce the load on clinic pharmacies.

Vaccine to stop heart attacks
The Daily Telegraph, London & Sunday Times, 1 April 2012
A vaccine delivered in an **injection or nasal spray to prevent heart attacks** could soon be available. It can **cut the build-up of fat in arteries by up to 70%,** according to tests by researchers at Lund University in Sweden. Prof. Peter Weissberg from British Heart Foundation said the vaccine was "very promising".

Cancer patent row 'public health issue'
Business Day, 23 April 2012
Health activists are lobbying the Supreme Court of Appeal to consider the broader issue of the **constitutional right to health** when it weighs up commercial interests in a legal fight between two pharmaceutical companies next month. **The court will consider an appeal lodged by Sanofi after it failed to get the patents commissioner to interdict Cipla from selling its generic cancer drug for patent infringement. SA's patent office does not examine the detail of patent applications, so it is up to interested parties to challenge their validity once they are registered.** The commissioner ruled last year that Aventis's patent was ambiguous and therefore unenforceable. Aventis appealed to the court to have the ruling scrapped. **The case will be heard on May 15**.

6. FINANCIAL NEWS

Doctoring figures of healthcare
Editorial Comment by: Garth Zietsman*, *The Star, 17 April 2012*
Due to escalating costs, private medical schemes will no longer exist in a decade or so, predicted Health Minister Dr Aaron Motsoaledi earlier this year, and used anecdotal evidence to compare the huge cost differences between public and private hospitals.

To make a fair comparison, we have to compare **overall hospital costs per patient**, after controlling for: **differences in the reason for treatmen**t (type of problem), the **severity of the condition** (number of days' admission involved), the **risks involved** (extra procedures or expertise necessary to counter these), as well as the fact that at public hospitals patients do **not have to pay VAT,** unlike patients in private hospitals. **In a comparison by Innovative Medicines SA (IMSA) (**before introducing the controls mentioned above) it found on average, that **private hospital costs were 1 438 times more expensive than public hospital cost**s. However, after **equating like for like**, it found that **private hospital costs were 1 053 times that of public hospital costs.**

Economist **Mike Schussler compiled statistics from independent sources such as Statistics SA**, the **National Treasury** and the **Council for Medical Schemes** reports. He says on **average 100% of the cost** in private hospital care is borne by the **client**, whereas only **2%** of the cost of **public hospital care is charged to the client**. Just because a public hospital client doesn't pay 98% of the cost of their care doesn't mean that this cost does not exist. Someone else (a taxpayer) has to do the paying. Channelling this payment via the government, instead of it being paid directly to the hospital, involves a significant portion being **diverted into the government itself to cover administration and the like**. In other words, the government funding figures **will underestimate the actual cost of public hospitals to taxpayers**. The IMSA relative cost equation above does not take into account this **inefficient channelling of funds through government** when estimating the relative cost to the economy of private and public hospitals.

The **declining public admission rates per capita,** in the context of **high mortality** proofs Government's **healthcare policy leads to less care for the poor**.
***Zietsman is a statistician**

BHF concerned by tax credit changes
Fin24, 13 April 2012
Dr Rajesh Patel, head of benefit and risk at **Board of Healthcare Funders** (BHF), says the board is concerned that **tax credits would fail to positively affect low-income employees** if the credit could only be used to **offset a tax liability in the year of assessment**. The **state decided to ignore all the BHF's advice**, says Patel. The credit system was introduced on March 1 this year, at a rate of R230 a month for the first two beneficiaries and R154 for every further beneficiary. **Up to March** this year, taxpayers qualified for a set **monthly deduction** on their taxable income, based on their family composition. It was contended that **monthly deductions** were **more rewarding to wealthier**

taxpayers. According to Johan Lombard, actuarial specialist at Momentum Health, the **new tax credit system** ensures the **same monetary benefit to everyone** in the form of tax credits. Individuals in lower tax brackets would receive slightly more than before and individuals in higher tax brackets slightly less in monetary terms.

Unregulated pricing 'bad for healthcare'
Business Report, 25 April 2012
The Department of Health intends engaging the Competition Commission on a decision by the watchdog that **deregulated pricing in the private healthcare sector.** Health Minister Aaron Motsoaledi said the **lack of price regulation had created uncontrolled commercialisation in the private sector.** The **Competition Commission banned collective price benchmarking in the private health sector in 2004**. The Minister said the key to the NHI was the cost of healthcare and therefore the **regulation of the private sector would be among his.** As part of the drug policy review, the Medicines Control Council would be replaced by a new body, the SA Health Products Regulatory Authority. This body would not only **regulate medicines, but also medical devices**.

Aspen announces R2,1bn deal with GlaxoSmithKline; Stock still rising on GSK deal
Business Day, 20 April; Bloomberg via Business Report, 25 April 2012
Aspen Pharmacare, has acquired a selection of **over-the-counter products from GlaxoSmithKline**, the global pharmaceutical group, for **R2,1-bn.** The deal **includes established brands such as Zantac, Phillips Milk of Magnesia, Dequadin, Solpadeine, Borstol and Cartia which** generated £59,3m for GlaxoSmithKline in 2011. The deal comprises two transactions: a **Southern Africa deal** in which Aspen will acquire the products for **South Africa, Namibia, Botswana, Swaziland, Lesotho, Zambia and Zimbabwe for R252-m**; and another in which **Aspen's Mauritius** subsidiary **Aspen Global will acquire the products for the rest of the world**, **excluding Europe** and **North America**, for R1,8-bn.

Nestlé nears a deal for Pfizer unit; Zurich authorities may make Nestle sell SA part of Pfizer
Reuters via Business Day, 24 April; Reuters, 19 April 2012
Nestle might sell the South African portion of Pfizer Nutrition to gain regulatory approval for **the $11,85-bn acquisition of its US rival's baby food business**. Analysts speculated competition authorities would **order the Swiss food group to sell 25% of Pfizer Nutrition**. The Pfizer unit is a **high-growth, $2,1-bn turnover business** with more than **70% of sales in emerging markets** and a **key position in China.** Likely buyers are Heinz or Danone. Nestlè said the Pfizer business should boost its margins and it forecast sales at $2,4-bn this year.

AstraZeneca set to buy Ardea
Reuters via Business Day, 24 April 2012
AstraZeneca has agreed to buy US company Ardea Biosciences for $1,26-bn in a deal that feeds a wave of mergers and acquisitions in the biotechnology sector. The main asset secured by AstraZeneca is an **experimental drug called lesinurad** that is in its final-stage clinical tests for **treating chronic hyperuricaemia in patients with gout**. AstraZeneca is f**acing competition from cheap generic versions** of several key drugs, including its big-selling antipsychotic Seroquel.

Loss of patent protection hits Novartis profit
Bloomberg via Business Day, 25 April 2012
Swiss pharmaceuticals giant **Novartis** said its first-**quarter profit dropped 8%** because of **generic competition** (Diovan, loses patent protection this year) and **manufacturing glitches** at a health products factory in Nebraska. Novartis expects sales this year to be in line with last year's at constant exchange rates, while its core operating margin would be "slightly below" last year's**. Consumer-health sales slumped 20% to $932m**. The company **suspended production at the Lincoln, Nebraska**, and recalled some products because they may have contained **broken** or **stray tablets from other medicines.**

7. GENERAL NEWS

Battle looms over shock move to ban liquor ads
Business Day, 16 April 2012
A **shock draft bill** from the Department of Health that **totally prohibits the advertising and promotion of alcoholic products is being reworked** behind closed doors by an interdepartmental government task team. **The Control of Marketing of Alcoholic Beverages Bill**, seeks to: totally **prohibit the advertising of alcoholic product**s; permit **only notices** (accompanied by a health warning) "describing the price, brand name, type, strength, origin and composition of the product", to be displayed; **prohibit the display of names and logos of alcoholic beverages on delivery vehicles**; prohibit the **linking of sports sponsorship to alcoholic brand names**; and, prohibit the **promotion of alcoholic beverages through donations and discounts** at events.
A recent **study by marketing analyst Chris Moerdyk** found the **media industry stood to lose R2-bn in revenue if alcohol advertising were to be banned - which amounted to about 2 500 job losses.**

MRC 'needs new backer'
Business Day, 30 April 2012
An official review of the Medical Research Council (MRC) has **recommended that it be moved from the jurisdiction of the Department of Health to the Department of Science and Technology**, on the grounds that the **pressures of service delivery have left it badly neglected.** Prof Wieland Gevers, who chaired the review panel, said the Health Department had neither the time nor capacity to support research at the council. He said the Department of Science and Technology's first priority was **research and development, adding that it had the ear of the Treasury and could raise the money.** Apparently **the Health Department had rejected the recommendation** that its reporting line be moved to science and technology.

New imaging unit gives sports medicine a boost
The Business Times, 8 April 2012
Pretoria's reputation as South Africa's centre for high-performance sports medicine received a boost with the l**aunch of an advanced imaging machine** capable of **seeing sports injuries in the highest resolution possible.** The Philips 3.0 Tesla MRI (magnetic resonance imaging) unit installed at Little Company of Mary Hospital in Groenkloof is a first for the country. Imaging technology is becoming increasingly important in diagnosing medical ailments, primarily due to the rapidly evolution of medical technology that has **enabled doctors to produce lifelike images of internal organs and injuries** quicker than before.

Dialysis treatment offered at night
SAPA, 6 April 2012
People suffering from kidney failure can now **receive dialysis treatment at night**. National Rental Care (NRC) CEO Noeleen Phillipson said going for haemodialysis at night would **allow patients to be more productive.** While haemodialysis is usually done over a four-hour period, o**vernight dialysis is performed over a period of eight hours.** This allows for a slower blood and dialysate flow rate, which tends to have a **less severe effect on the vascular system.** The overnight options are Greenacres, Port Elizabeth, Netcare Sunninghill Hospital in Johannesburg and at Netcare Umhlanga Hospital in KwaZulu-Natal..

Mental health disorders a concern
SAPA, 13 April 2012
Neuropsychiatric disorders have the **third highest disease prevalence in South Africa behind HIV and other infectious diseases**, according to Health Minister Aaron Motsoaledi. He said that **43% of people living with HIV also had a mental disorder.**

Teens swap books for babies

The Sunday Times, 15 April 2012

Statistics SA reports that **160 754 schoolgirls fell pregnant between July 2008 and July 2010**. The General Household Survey 2010 found that **Limpopo had the highest number of teenage pregnancies**, followed by KwaZulu-Natal. As there are no department regulations concerning pupil pregnancies some schools are barring pregnant pupils from attending class for a year. The director-general of the Department of Health, Malebona Matsoso, has **ruled out the possibility of providing contraceptives to pupils**.