SUMMARY OF HEALTH NEWS: SEPTEMBER 2012

September's news highlights:

Key note speakers at the recently held Hospital Association of SA (HASA) conference in Cape Town made several proposals and suggested new projects, which – if implemented – could transform SA's public and private healthcare sector dramatically. The same can be said about new projects the national Department of Health have announced. To note but a few:

1. That private **hospitals provide services to public sector patients through innovative public private partnerships (PPPs):** (Netcare CEO, Dr Richard Friedland, referring to an 18-year PPP in Lesotho)

2. That the **current set of PMBs be replaced with an "essential healthcare package".** (Dr Humphrey Zofuka, CEO of BHF). **Health Director-General Precious Matsoso** also appealed to the private health sector to come up with good **"contracting models"** where the state could, as an example, **partner with private doctors to deliver services**.

3. **That an investigation into the private medical business should be conducted by an independent and unbiased body – not the Competition Commission** who is an 'agent of the state', being used as a "blunt tool to achieve policy and ideological objectives". (Editorial Comment *Business Day*, 11 September)

4. That the Department of Health (DoH) **effectively implements** its proposed projects: a R1,2-bn plan to **upgrade and expand the country's nursing colleges;** a **scheme to increase the number of doctors** the country produced; **regulatory measures** to improve the functioning of the health system; an Office of Standards Compliance, which will set **minimum health standards** for all health facilities; etc.

5. That **a properly run HIV-programme, to change behaviour over 10 years, be implemented as spending now** on effective prevention will save expensive, life-long treatment in the future. (Researchers Nicola Deghaye and Alan Whiteside HIV/AIDS research: University of KZN)

However, these suggestions will be worth less than the paper they were written on if the DoH does not effectively implement an ethical code of conduct. The transformation of SA's malfunctioning, chaotic public healthcare, as well as problems in the private healthcare sector, will **not be possible if it is not founded on an ethical code that does not tolerate** corruption, fraud, poor performance, lack of productivity and bad management. (*Zero tolerance has become a meaningless buzz word, but maybe that is what we need)*

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1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

Research: Going backwards: Interview with MRC Pres Salim Abdool KRM; Fears over health units
Troye Lund: The Financial Mail, 7 September; The Times, 31 August 2012
The Medical Research Council (MRC) is the **custodian of all medical research in SA**. It funds 27 in-house research units and 23 in hospitals and universities. Government allocated **R246m in 2012**; 43% (R67m) is spent on in-house research and 19% on university-based research. However, the funding is not nearly enough as **one drug study** on malaria, for example, costs **R15m.**

* SA's ability to combat HIV, tuberculosis and cancer could be in jeopardy due to **funding cuts to the MRC.** Two of its food safety and security research units might close down. Other units might also be affected and staff cuts are in the pipeline. **The MRC was prioritising the top 10 causes of death and disease.**

Motsoaledi welcomes inquiry into private healthcare
Business Day, 10 September 2012
Health Minister Aaron Motsoaledi has welcomed the Competition Commission (CC)'s **proposed market inquiry into SA's private healthcare** sector and the cost of healthcare in the country. The success of the NHI system depended on an **improved and overhauled public healthcare system and the regulation of private healthcare costs, he said**. He wanted no finger-pointing and **acknowledged the deteriorating quality of care in the public sector,** Motsoaledi said.

Health Minister slams 'tender-care' system
Mail & Guardian, 14 September 2012
People who opposed the formation of the NHI in SA were "opposing something they don't understand", said Motsoaledi. Those who i**ssued health tenders for things that had nothing to do with health** were driven by **"uncontrolled commercialism"**. He also complained about the tendency in **private hospitals towards a "medical arms race"** where **expensive, non-essential equipment was purchased** and the price passed on to the consumer.

* Motsoaledi outlined various projects that the DoH were pursuing: a R1,2bn plan to **upgrade and expand the country's nursing colleges;** a **scheme to increase the number of doctors** that the country produced each year from 1 200 to 3 600; **regulatory measures** to improve the functioning of the health system; an Office of Standards Compliance, which will set **minimum health standards** for all health facilities; **hospital boards** - similar to school governing bodies - to ensure that there is community oversight over healthcare facilities; and a school health programme.

* However, **he shied away from questions on how the state would pay for NHI.** Motsoaledi also moved to **quell fears that government planned to end private healthcare.**

R200m for health of pregnant women, children
Business Day, 12 September 2012
BHP Billiton has donated R200m to fund early childhood health projects in SA and Mozambique by international health organisation PATH. The project is expected to help at least 750 000 children and pregnant women in Gauteng, KwaZulu-Natal, Mpumalanga, the Northern Cape and Maputo.

State in bid to partner private healthcare Partnerships can boost hospitals
Business Report, 21 September; SAPA, 27 September 2012
Addressing the annual Hospital Association of SA (HASA) Conference Health Director-General Precious Matsoso has appealed to the private health sector to come up with good "contracting models" where the state could, as an example, **partner with private doctors to deliver services**. She said this **might be necessary if the government wanted to roll out the NHI system**. The private sector could also make **facilities available to train state workers**

on how to provide quality services. Government might use some of the NHI pilot sites to try the model where GPs deliver some of the services, she said.

* At the same conference **Netcare CEO Dr Richard Friedland** said there is no reason why **private hospitals cannot provide services to public sector patients through innovative public private partnerships (PPP's)**. Netcare operates **an 18-year PPP in Lesotho** where the Lesotho government is the purchaser of services, while Netcare is responsible for the full spectrum of clinical care. The PPP had enabled the hospital to **see more than 400 000 outpatients and more than 23 000 inpatients in the 12 months since it opened**. The most critical factor in ensuring long-term sustainability was **ongoing training and skills transfer to local staff. EI SA, the UK-based Any Qualified Provider concept of service provision could be adapted** and implemented. Friedland compared it **to a mixed-price airline model**, where economy and business class passengers were serviced together. The Lesotho PPP model was affordable and workable in SA, but would require legislative and **regulatory changes in terms of employment of doctors, but also a philosophical mind shift.**

* Meanwhile, a **British health economist**, Andre Street, cautioned that **some hospitals might have to be paid more for their services to encourage them to participate in the NHI system** as this was what the UK did when it initiated its service. He said the **diagnostic-related groups (DRG) system**, had proven to be the **fairest system** where some hospitals had to lower their prices to cater for the greater part of the population.

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

HIV budgets come under pressure
Mail & Guardian, 21 September 2012
International response to HIV is shrinking and commitments are uncertain because of the **global economic crisis, donor fatigue and other factors**. **Governments have to take more fiscal responsibility for HIV.** According to Treasury data, total spending on HIV was R16,9bn for 2010/11, of which R5-bn was from donors.

* More recently **economists have entered the ranks of the key HIV decision-makers**, resulting in an increasing **emphasis on investing strategically and directing resources where they will have the greatest impact and provide the best value for money.** Preliminary **results of the first SA national AIDS spending assessment** show that the **antiretroviral budget is dwarfing all other spending on HIV. About 10% of SA's total spending on HIV was on prevention** with **s**everal provinces spending less than 10% on prevention. The large variations in spending suggest the provinces find it difficult to establish what the best strategies are, and spend a little on everything. It is harder to show that **a properly run programme to change behaviour over 10 years can produce positive results because it is difficult to isolate the effect of the programme from all the other influences.** Spending effectively on prevention is an investment. Spending now on effective prevention will save expensive, life-long treatment in the future.

Nicola Deghaye: researcher: health economics and HIV/AIDS research division, Univ. of KZN and Alan Whiteside: director

Many too poor to access free health services
Health-e News Service, 7 September 2012
A study by UCT's Health Economics Unit on two SA communities, investigating the costs involved in accessing health services, found **that on average TB patients had spent R100, and HIV-positive patients on antiretroviral treatment (ART) R81, on travel each month to access treatment, while pregnant women paid R321** to access obstetrics services during their pregnancy. These direct **costs exceeded 10% of total household expenditure in two-thirds of households using obstetric services, in one-third of households with a member receiving TB treatment and in 23% of households with a member on ART**.

Kwa-Zulu scientists 'hold key' to HIV
Business Day, 27 September 2012
The University of KwaZulu-Natal, in partnership with the US-based Howard Hughes Medical Institute, has **built a $40m research institute to seek better treatment for HIV and tuberculosis (TB). Eight investigating scientists had been recruited to work in the institute** and would be supported by clinical studies support groups specialised in microbiology, immunology and pharmacology.

* Meanwhile Deputy President Kgalema Motlanthe has launched an HIV intensification campaign for public servants. The aim is to get 1,3m public servants to test and know their HIV status.

Beating cancer at its own game
Mail & Guardian, 28 September 2012
Five steps could reduce deaths from cancer in SA, according to the Cancer Association's head of research, Dr Carl Albrecht: **Vaccinate all 10-year-old girls** against human papilloma virus (HPV). Cervical cancer - caused by HPV - is the second most common cancer among women; **gather accurate information on cancer** prevalence, incidence and tendencies; **modernise equipment**; create a cancer **council to co-ordinate cancer-fighting efforts**; and **use tax** (R8bn are raised in tobacco taxes every year) for **health promotions**.

3. DOCTORS, NURSES, HOSPITALS & TRAINING

'Country needs cheaper hospitalisation models'
Business Report, 25 September The Times, 25 September 2012
Longer stays in ICUs, the use of more expensive drugs when patients are admitted to hospitals, a dramatic increase in "in-hospital" pathology, and extended periods spent in hospital for procedures are some of the **reasons private hospital costs have escalated** way above consumer and medical inflation rates, said Discovery Health CE Jonathan Broomberg at the recently held HASA Conference. If hospitals could perform medical **procedures in a shorter time, patients could pay a fraction of current hospitalisation fees**. He showcased a pilot project run by Discovery in which it **cut the number of days patients were hospitalised for hip replacement surgery from seven days to three-and-a-half days**. This resulted in the t**otal cost decreasing to R70 000** compared with the R110 000 charged by the private hospitals. **He said high-volume surgeries should be created. New technologies, new facilities** and **doctors' decisions in referring** patients to hospitals were the supply drivers. This raised a question as to whether new hospitals being built were just another reason for increased utilisation, said Broomberg.

* **Medi-Clinic's** funder relations head, Roly Buys, reacted that SA did **not have the number of doctors and nurses needed to run high-volume surgery centres.**

* **Nigel Edwards,** KPMG's director: health systems for auditing, said hospitals should focus on integration of all levels of care and the employment of doctors by hospitals should be considered. **The answer was not low-cost hospitals, but low-cost systems,** he said**.**

Gauteng health 'pushing hospital upgrades'; Outcry over hospital closure; Hospital beds unused; Doctors work by cell phone light; Generators and new MEC are now switched on; Litigation looms in E Cape; Recovery plan for Gauteng health department; Drop in newborn deaths in Gauteng
SAPA, 6, 24 September; The Star, 11, 17 September; The Times, 11 September; Business Day, 6 September; Health-e News Service, 25 September; Citizen, 27 September, 2012
* The Gauteng health department received a **qualified audit** opinion based on its **revenue, irregular expenditure, leave entitlement and capped leave commitments.** The department has since appointed a CFO, Ndoda Biyela, to ensure there were **tighter financial controls, improved contracts management and that the departments complied with the Public Finance Management Act**.

* Gauteng's head of health, Nomonde Xundu, **admitted to parliament's** portfolio committee for health that many of **the revitalisation projects intended to improve the capacity** of some of the biggest and most specialised hospitals, **were behind schedule and over budget**. This was due to red tape, change of plans at several hospitals and interest charges on delayed projects.

* Medical staff at Chris Hani Baragwanath Academic Hospital recently had to **use the light from their cell phones to complete a caesarean section**, and **manually give oxygen** to a patient on life support, during yet another **power outage.** The DA's provincial spokesman on health, Jack Bloom, said the outage was the seventh this year as the **hospital's generators failed to kick in.**

* In its **editorial comment** (12 Sept), under the heading, ***Bara, place of shame, The Star*** asks: "Surely there can be **no good reason for a complete power outage** for more than two hours at one of the country's most important and busiest institutions? Bara has long been **a place of shame for Jo'burg**, in a country where all too many public hospitals fail to deliver."

* The l**atest news on the power failures** at Bara was that an investigation team found that the **new generators were not switched on** and **hospital staff did not have keys for the plant room**

* **17% of intensive care unit (ICU) beds are not operational in Gauteng public hospitals** due to **budget constraints,** according to the DA' health spokesman Jack Bloom. Steve Biko Academic Hospital had the most unused ICU beds, at **17 out of 60**, followed by Chris Hani Baragwanath, at **10 out of 49**. Earlier this year, it emerged that medical staff faced such shortages that they said **at times they had to decide who lived when choosing who to treat first.**

* Good news from Gauteng is that **maternal deaths** at public health facilities has **decreased from 167,7 per 100 000 live births during 2005/2007 to 145 per 100 000 live births during 2008/2010**. An additional **Kangaroo Mother Care Unit** (whereby breast-fed premature infants remain in skin-to-skin contact with mothers instead of being placed in incubators) was opened at the Tshwane District Hospital.

* People from Gugulethu and Manenberg have been protesting **against the planned closure of the GF Jooste Hospital** as the poor would not be able to afford travelling to Groote Schuur Hospital. The hospital will be **closed in December, rebuilt and reopened only in 2016**. It serves about 1,6m people.

* **Eastern Cape Health and Treasury MEC's** have been given **an ultimatum to either reply to a set of questions related to the staffing crises at Madwaleni and Livingstone hospitals, or face litigation.** Madwaleni, a 180-bed rural hospital, is now **operating with one doctor instead of 14. Livingston Hospital, in Port Elizabeth,** has been **unable to replace specialists and medical officers lost through attrition due to the moratorium**. Many health workers have **not been paid.**

Skeletal health system sitting on cash pile

The Times, 7 September 2012

"As thousands of patients die, waiting for life-saving treatment, **several provinces are sitting on a staggering R800-m earmarked for improving healthcare.** The failure of five provinces - KwaZulu-Natal, Eastern Cape, Free State, Limpopo and Northern Cape - to spend on vital infrastructure and equipment not only disastrously affects basic healthcare but **could hamper the introduction of a NHI scheme**." Health Minister Motsoaledi r**evealed in parliament that the five provinces had underspent their allocations for the hospital revitalisation programme by almost R2-bn**: Eastern Cape - R191m; KwaZulu-Natal - R228m; Free State - R134-m; Limpopo R89m; Northern Cape - R158m. He said the failure to spend **was due to delays in the awarding of tenders, rolling-over of budgets from the previous financial year, poor performance by contractors, termination of contracts and court challenges.**

4. MEDICAL AIDS

Bid for clarity on medical PMBS fails

Personal Finance, 22 September 2012

The **Supreme Court of Appeal denied the BHF and the municipal workers' medical scheme the right to appeal** against the **dismissal of their application for clarity over medical schemes' obligation to pay prescribed minimum benefit (PMB) claims at full cost**. The court **did not give reasons for its decision**. The North Gauteng High Court was originally asked to clarify the meaning of a regulation under the Medical Schemes Act that says medical schemes must pay PMB claims in full. The **CMS** has interpreted the regulation to mean that claims for PMBs **must be paid at the providers' invoiced price**. Medical schemes supporting the BHF say this interpretation of the regulation **gives providers a blank cheque** to charge as much as they like for PMB services. In **November 2011 the High Court dismissed the BHF's application**, saying it did not have legal standing to ask the court to clarify the PMB matter. The judge said schemes affected by the PMB regulation should have brought the application to the court. Dr Humphrey Zokufa, (MD of BHF), said **the denial of the appeal was a barrier to getting clarity on the PMB regulation, and had implications for other organisations and their right to represent their members**.

* The BHF's **application for an exemption from the Competition Act to allow medical schemes and providers to negotiate providers' tariffs has also been rejected.**

Fair-pricing forum for healthcare may be set up; Taking healthcare's competition pulse; Healthcare competition inquiry 'may not address cost problems'

Personal Finance, 1 September: Business Day, 4 September; Business Day, 21 September 2012

* Health economist Nicola Theron has **questioned whether the CC's planned healthcare inquiry would address the problems facing SA's health system.** The CC is deciding on the scope of an inquiry it plans to hold into the healthcare sector, a move many industry players fear may be the first step towards the government regulating prices. At the HASA Conference Theron said Econex research showed **60% of the real increase in medical schemes' expenditure on hospital fees was due to factors other than price, such as older, sicker patients, longer hospital stays and new technology.** This **contradicts the CMS's argument** that medical schemes' increasing hospital expenditure has been driven by the **lack of competition** in the hospital market. However the **Competition Tribunal had given the go-ahead to hospital mergers opposed by the CC.** It found no evidence that these mergers would have an adverse effect on prices, she said.

* The CC's inquiry into healthcare costs will consider **what is driving costs, how the market has evolved** since negotiations between schemes and providers over healthcare tariffs were stopped and the **policies that could be adopted to address problems in the market**. Policies flowing from the inquiry's findings are expected to be **less susceptible to legal challenges from healthcare providers.** At the parliamentary hearings, medical practitioners and medical schemes said they supported the concept of a forum that would set fair prices for medical services. Representing medical schemes, Zokufa (BHF), said **pressure should be put on the CC to reverse its rulings, and an opportunity for tariff negotiations should be reintroduced.**

* Trudi Makhaya, the CC's head of advocacy, said opinion was split between **those who argued that healthcare costs were driven up by older, sicker people making greater use of their medical aid funds**, and others who thought **cost increases were a reflection of market power exercised by the players.** The **Competition Act in its current form does not provide for formal market inquiries**, nor does it empower the CC to summon people to provide information. However, the Competition Amendment Act, passed by parliament but given no effective date, provides for market inquiries and gives the CC special powers to summon witnesses and to require individuals to give evidence under oath.

* Robert Wilson, a partner at law firm Webber Wentzel, said the question would be: C**ould competition be enhanced in order to result in lower prices and better quality services, or were these markets better served by regulatory interventions?** The **terms of reference** for the inquiry would be **critical.**

* Makhaya said the CC's **preliminary research** had identified **key relationships in the industry that were not working,** such as **doctors not moving patients in the most cost-effective manner** through the system. A **balance between competition and regulation** was needed, adding that "extremes" did not work.

Regulator advises smaller medical schemes to merge
Business Report, 11 September 2012
Rising medical costs have prompted the CMS to **ask some medical schemes with deteriorating finances to consider an amalgamation.** The **National Independent Medical Aid Society** is in negotiations to **merge with Resolution Health**. The health economist at Econex, Mariné Erasmus, said the deteriorating financial position of medical schemes had more to do with their **risk profile as a result of regulatory changes**, which instituted the open enrolment concept, **preventing schemes from cherry-picking some members and rejecting others.** The CMS said 60% of open scheme beneficiaries were in schemes that did not meet the 25% minimum solvency requirement. Small schemes spend about 15% more on beneficiaries' claims than larger schemes. This might be due to a worse profile of lives, as small schemes had an older average age.

Medical aid trustees 'are coining it'
The Times, 5 September 2012
The **highest-paid trustees highlighted in the CMS's annual report** were: Liberty Medical Scheme trustees an average of: R703 000 a year; Medshield Medical Scheme - R422 000; Spectramed - R380 000; Fedhealth Medical Scheme - R297 000; Discovery Medical Scheme trustees - R257 000.

* **Discovery Health Medical Scheme's principal officer,** Milton Streak, reacted: "the fee was appropriate considering the size and complexity of the business with an annual income of R35bn".

* **Liberty's principal medical officer, Andrew Edwards**, said trustees managed huge amounts of money and could "be held financially liable in their personal capacities and therefore had to be highly skilled".

Court acts on medical fund over 'risk, fraud'
Business Day, 6 September 2012
Sizwe Medical Fund was placed under provisional curatorship after it emerged that **its principal officer,** who was managing R2bn, **had not finished school and there were alleged financial irregularities** in the scheme and **fraud in the election of its trustees**. Sizwe has 156 000 beneficiaries. It had a solvency ratio of 27% at the end of last year. Marshall Gobinca was appointed provisional curator of Sizwe.

Medical Schemes' increase rates for 2013
Business Report, 21 September; Personal Finance, 1, 27 September 2102
Discovery - 10,9%; Profmed - 8,56%; Momentum Health - 7,9%; Medshield Medical Scheme - 7,5%; Topmed - 9,47%; Compcare - 6,9%; Pharos - 10,8%; Fedhealth - 7,9%.

Bonitas still hopes to recover property losses
Personal Finance, 15 September 2012
After **a year under curatorship**, Bonitas Medical Fund has **recovered only a few of the millions its previous board of trustees spent on inappropriate property** and other deals, according to a report by the outgoing curator of the scheme, Joseph Maluleke. **Criminal investigations into the loss of some R60m** of members' money to fund a questionable property development (Clansthal) and other investments were ongoing. The Gauteng South High Court lifted the curatorship and ruled that Bonitas was ready to be run by its newly-elected board of trustees. **Maluleke recovered more than R11m** for Bonitas by selling two properties the scheme owned. Bonitas is seeking to **amalgamate with Pro Sano Medical Scheme**, and was in negotiations with another scheme over a potential merger. Last year, Bonitas made a surplus of R158,8m.

Discovery aims to limit health inflation; Market shaker; In fine fettle despite cost pressures;
Business Day, 6, 14 September The Financial Mail, 14 September; 2012
At the release of its financial results, Adrian Gore, CEO of Discovery Holdings, said Discovery was going to use its scale to **create a balance in the spiralling cost of healthcare by negotiating with hospital groups and health service providers**. Discovery Health experienced the **lowest-in-industry lapse rate at 3,9%.** Gore said the scheme had gained a **significant share of young and healthy members**, who were buying low-cost plans. The Discovery Health medical scheme had a 4,5% increase in total members under management to 2,4m in the 12 months to June. Discovery Holdings grew its operating profit by 21% to R3,4bn in the year to June. Since listing in 1999 the share price has gained close to 700% to about R56. Discovery has **increased its earnings by 21%** in the financial year. The largest contributor to the group is Discovery Life, which accounts for 53% of operating profit, or R1,82bn.

* Discovery Health Medical Scheme (DHMS), has been under **intense scrutiny after members challenged the size of the administration fees it pays Discovery Health**. CE Jonathan Broomberg said DHMS had about 2,4m members at the end of 2011, representing half the open medical schemes market.

* DHMS continued to attract new members, had a low lapse rate of 4%, and had a significantly **younger age profile of 31,8** last year, compared with the industry average of 34,8**. (Also read: Addendum: p.13-15)**

Medical and Dental Professions in HPCSA tariff guidelines discussions
Press Release 3 September
The SA Medical Association (SAMA), the SA Private Practitioners Forum (SAPPF) and the SA Dental Association (SADA) made their **respective representations regarding tariff guidelines to the HPCSA** following a decision by HPCSA to **place on hold publication in the Government Gazette of its proposed tariff guidelines**. "It may seem counterintuitive, but we do believe that proper and full consultation will yield a quicker and fairer result than the Medical and Dental Board trying to railroad through an ill-conceived and inappropriate and unfair benchmark tariff that will bring forth a spirited legal challenge," said **Dr Chris Archer,** CEO of the SAPPF. **Dr Mark Sonderup**, Acting Chairman of SAMA agreed that any benchmark tariff for doctors and dentists should be based on a **fair and transparent process** that incorporated important principles such as the actual cost of running a practice, tiered consultations, and an updated codes and procedure list.

Maretha Smit, CEO of SADA, pointed out that it is **not within the mandate of the Council to publish tariffs**. **The role of the HPCSA is to guide ethical behaviour** according the National Health Act s90(1)(v).

Integration can cut costs
SAPA, 27 September 2012
The healthcare industry needs greater integration to bring down medical scheme costs, said Discovery Health CEO Jonathan Broomberg at the HASA Conference. He said that medical inflation at 10,9% was almost double general consumer price index inflation of 5,5%.

The three fundamental drivers of cost are: **new technology; new facilities opening; and, doctors' decisions. Increased hospital utilisation was responsible for 40% of the increase in hospital inflation**. Broomberg said new, life-changing technologies were available which schemes were under pressure to fund: trans-catheter aortic valve implantation cost between R321 000 and R552 000 versus older open heart surgery procedures of R250 000. Medical **schemes needed to find ways of funding life-changing drugs**. He suggested **mandatory cover for the employed** and **longer waiting periods for new** to rein in costs. **Healthcare teams needed to be integrated and more risk sharing models explored.**

Civil society wants health insurance rules altered
Business Day, 21 September 2012
Civil society groups have appealed to the Ministers of Health and Finance to reconsider plans for regulating

health insurance products, saying they do not go far enough to protect consumers. In March, the Treasury published **draft regulations to the Long-Term Insurance and Short-Term Insurance Acts**, seeking to draw a clear distinction between **medical schemes and health insurance policies**. The regulations proposed **scrapping most gap-cover products**, but would allow health insurance for loss of income, travel, emergency travel, HIV/AIDS and frail care. The draft regulations, which were open for public comment for six weeks, elicited **strong criticism from companies selling gap cover products**.

* **Civil society groups have raised concerns** about **the details in the regulations and the way Government has conducted its public consultation process**. An open letter, addressed to both ministers, was written by **the Helen Suzman Foundation**, rights **group Section 27,** and Wits social security **Prof Alex van den Heever**, stating that the proposed legislation could **destabilise the medical schemes industry**. Researcher Kate Francis said **civil society was concerned about possible collusion in the market, whereby medical schemes and their administrators deliberately created holes in their products that could be filled by their chosen providers of gap cover**.

* The spokesman for the Health Ministry said the Minister was **prepared to meet them and would also be discussing it with the Minister of Finance**.

BHF News: State urged to review outdated protection plan; Council looks to govern doctors' fees; Medical aid schemes rely on cross-subsidisation balance

Business Day, 27 September 2012 Reporter*:* David Jackson

The current set of PMBs has had many unintended negative consequences for the sector, according to Dr Humphrey Zokufa, CEO: Board of Healthcare Funders (BHF). These range from a cost spiral in the absence of a single tariff for PMBs, to a lack of clarity of interpretation and guidelines pertaining to these benefits. T**he BHF has asked government to urgently review the PMB package** and replace it with an **"essential healthcare package"**. The proposal was guided by the principle of **"coverage for all and not coverage of everything",** said Zokufa. The package should provide a **minimum compulsory set of benefits that all health insurers should cover.** He said it was hoped that the proposed essential healthcare package would be implemented soon to **ensure a seamless integration to the NHI scheme.**

* The **Health Professions Council has been trying to introduce a set of tariffs that would essentially govern the fees that medical practitioners and dentists can charge**. The doctor or dentist would have to obtain the patient's written consent to charge any fee that falls outside the prescribed tariff. The designated service provider, or network doctor or hospital group model, is seen as a way of containing costs for members without them having to make upfront payments.

* Heidi Kruger, head of communications for the BHF, said there **could be co-payments in some instances: where there was no arrangement between health practitioner** and scheme and the health practitioner charged more than the medical scheme was able to pay according to its rules. **Co-payment might be levied** where a patient sought to use an **expensive drug when a generic was available** on the medical scheme's formulary.

* The recently-enacted **Consumer Protection Act stipulates that rules and agreements across the business spectrum should be written in "plain language" for the benefit of consumers**. Kruger said that most medical schemes were working hard at the moment to put their rules into plain language.

* A **key element of community rating** - a core principle in the functioning of medical aid schemes - **is cross-subsidisation**, said Zokufa. This is the system whereby **the young and healthy members of medical aid schemes subsidise the elderly and sick through their medical aid premiums**. Because medical aid was not compulsory, more and more young people may opt out of the medical scheme system, leaving an imbalance of elderly and sick people in the system which leads to rising costs. Zokufa said given that the money being paid out by medical schemes came from a pool of money to which all medical scheme members contributed, when people abused the system it meant the money was being wasted. He said it was

important for **medical schemes to know that the drugs on their formularies and the benefits they offered through the various options were based on best practice principles.**

5. PHARMACEUTICALS

Cheaper biologics on cards for SA as Roche wins tender
Business Report, 10 September 2012
Biological medicines, or **biologics, could become more affordable and more accessible** if more of these drugs are **distributed to state hospitals**. Swiss multinational biologics manufacturer **Roche has lowered the price** of MabThera, used for treating lymphoma cancer, in public sector hospitals after it was awarded a tender to supply the drug. **Biosimilars, drugs that were copies of biologics, should reach SA in two to three years**, and were expected to reduce the cost of biologics by 25% or even 50%.

New authority to foster ethical drugs marketing
Business Day, 14 September 2012
The medical industry launched a **Marketing Code Authority** to ensure more **ethical advertising and promotion of medicines, devices and laboratory tests.** The authority will **enforce a marketing code** that spells out the do's and don'ts for the industry, including stiff penalties for offenders.

The groups that have signed up to the Marketing Code Authority include: IMSA; the National Association of Pharmaceutical Manufacturers; Pharmaceuticals Made in SA; the Pharmaceutical Industry Association of SA; the SA Animal Health Association; the SA Laboratory and Diagnostics Association; the SA Medical Device Industry Association; and the Self Medication Manufacturers Association of SA.

* **Complementary medicines could not be included** because they were unregulated.
  The Health Products Association (HPA), a trade association for companies selling complementary medicines, has its **own marketing code**, which will be presented to the Advertising Standards Authority.

New twist in Cipla Medpro controversy; Cipla Medpro under investigation
Business Day, 4 September; Fin24.com, 21 September 2012
* **The Takeover Regulation Panel (TRP) has informed Cipla that it intends to conduct an investigation** into the affairs of the company **relating to a potential affected transaction**. A **complaint against Cipla was lodged on behalf of certain shareholders,** among whom the **company's suspended CEO, Jerome Smith**. The **complaint** included the way the board has handled a **potential deal and the suspension of its CEO**. His suspension resulted in **the company's share price coming under pressure and torpedoed takeover talks with an undisclosed third party.**

State determined to regulate logistics fees drug makers pay to wholesalers
Business Day, 25 September 2012
The **DoH has refused** to bow to calls from pharmaceutical wholesalers for it **to protect smaller players in the industry**. The government is **trying to regulate the logistics fees** paid by pharmaceutical manufacturers to wholesalers and distributors to get their medicines to pharmacies and doctors. This is **part of the government's broad push to control medicine prices and give consumers a better deal.** Wholesalers buy medicines from manufacturers and store them until they get orders. Distributors do not take on the risk of purchasing the medicines, and move them between manufacturer and retailer only after they have been ordered. One of the issues facing the wholesale industry is the extent to which the government's latest proposals will enable pharmaceutical companies to **negotiate logistics fees below the caps set by the government**. The DoH did not believe a **minimum fee** was appropriate, as it would be **anti-competitive**.

* Trevor Phillips, spokesman for the Pharmaceutical Logistics Association of SA, said manufacturers often

adopt a take-it-or-leave-it approach, particularly with small logistics providers. According to the **draft regulations four price bands with different maximum logistics fees will apply**. For medicines where the ex-manufacturer price is less than R100 (excluding VAT) the fee can be no more than 8% plus R3; medicines priced between R100 and R500, 6% plus R4; and those above R500 but less than R1 000, 4% plus R5.

Medicines priced at R1 000 or higher will have logistics fees capped at R54**. Phillips said logistics service providers would suffer "considerable" revenue losses if the draft regulations became law.**

A copy of the draft amendment http://www.info.gov.za/view/DownloadFileAction?id=174653

6. FINANCIAL NEWS

Merger will take Litha to healthy heights; Litha Healthcare forges ahead to tap into new markets
Business Report, 31 August, 7 September 2012
Litha Healthcare envisions its pharmaceuticals division becoming the fifth-largest generic medicines player in the local market after **acquiring Pharmaplan for R590-m**. Litha's pharma division **grew its turnover by 61%** in the half-year to June. Earlier his year Litha and the DoH reached an agreement to run the Biovac facility as a joint venture. Litha's operating profit lost 12 % because of lower sales in the medical unit, once-off costs relating to the Pharmaplan deal and costs of investment in the drugs unit.

* In its **annual report** Litha said the group's focus would now be on **increasing sales to public hospitals** and **exploring export opportunities for its different divisions.** In the short-term, Litha was looking **to expand its current packaging and assembly operations.**. Another priority is expanding into **Botswana, Mozambique, Namibia, Swaziland and Zambia. Litha is already selling vaccines and consumable medical products to these markets.**

Aspen: Prescription for growth? Aspen's earnings to rise 18%-24% ; Aspen sets sights on overseas growth
The Financial Mail, 7 September; Fin24.com, 30 August; Business Day, 13, 14 September 2012
Aspen Pharmacare will focus on **growing its Latin American and Asia Pacific businesses** after reporting a **23% increase in revenue** to R15,3-bn. from continuing operations increased. Operating profit was up 25% to R3,9bn.

* Aspen is spending **R2,2bn on 25 'established' products from GlaxoSmithKlline (GSK) - all post-patent,** meaning that any competitor can now make a generic version of the product, usually at a much cheaper price. GSK wanted to concentrate on new products. The Asia Pacific business was expected to become its biggest contributor to revenue once it started distribution of the GSK brands.

* In addition to its operations in **Brazil, Venezuela and Mexico the group plans to expand into Thailand, Taiwan and Malaysia**.

* Meanwhile North Gauteng High Court ordered the registrar of trademarks to **remove Aspen products branded Andosept from shelves** after Australian producer Wirra successfully opposed Aspen's application for leave to appeal against a ruling made last year. Andosept used **packaging similar to that used for Andolex.** Aspen changed the packaging but continued to sell the product under the name Andosept.

R1,6-m payout taken to court
The Times, 7 September 2012
The CMS has turned to the courts to **try to recover the R1,6-m paid to Boyce Mkhize** when he resigned as a trustee of the **Liberty Medical Scheme**. Mkhize, CEO of the National Nuclear Regulator, resigned as a trustee prematurely last year after the Liberty scheme merged with Medicover. The court case against Mkhize and Liberty Medical Scheme **might shed more light on what trustees, who usually work part-time, should earn and what responsibilities they should carry.**

7. GENERAL NEWS

Romney would keep parts of Obama healthcare law
Reuters, 9 September 2012
Republican presidential candidate Mitt Romney, who has **called for scrapping Pres Barack Obama's 2010 US healthcare law**, said in recent remarks that he **liked key parts of "Obamacare"** despite his party's loathing of it and wanted to retain them. One was to make sure that those with **pre-existing conditions could get coverage**. Two is to assure that the marketplace allowed for individuals to have policies that **cover their family up to whatever age they might like**. The Obama law was meant to bring coverage to more than 30-m of the roughly 50-m uninsured and slow soaring medical costs.

Tape measures for smokers?
Business Day, 21 September 2012
Amendments to the Tobacco Products Control Act and the effect of compelling tobacco companies to use **unbranded packaging** were recently discussed in parliament. Objections by MPs included that there was no "rationale" for greater restrictions on smokers' activities and that the intention seems punitive rather than aimed at improving South Africans' health. However, MP's would be on firmer ground if they were to **challenge the practicality of the proposed amendments** - such as that smokers on a beach should be at least 50m away from other people, or 10m from a window or door when smoking outside. The suggested **ban on branding** is also controversial as there is scope for unintended consequences, that will leave producers with little option but to **compete on price rather than quality,** and that lower prices might actually **encourage existing smokers to smoke more.**

Reducing salt intake can prevent thousands of cardio-vascular deaths a year
The Cape Times, 18 September 2012
According to research published in the *SA Medical Journal* **reducing salt intake can prevent 7 400 cardio vascular disease deaths annually. Bread and margarine had the highest salt content**. Soup powders and seasoning were the next highest. The World Health Organisation recommends a **daily salt intake of 4g to 6g a day** but the average **South African consumes 8,1g**. Salt content in food has to be decreased **gradually to allow the taste buds to adapt**.

China to expand insurance so sick don't 'lose everything'
Bloomberg, 17 September 2012
Health Minister Chen Zhu, a Paris-trained haematologist, announced that **China will expand national health coverage by roping in private insurers and including more major diseases**, as it seeks to **close the mortality gap between rural and urban residents while trying to contain costs**. China **will train more doctors, revamp public hospitals** and **cut medicine prices** to improve services and lower costs. Spending on healthcare in the country is forecast to almost triple to $1 trillion by 2020.

Killer bug investigated
The Times, 26 September 2012
The National Institute of Communicable Diseases is investigating a **deadly superbug that has killed five people since August.** The **New Delhi metallo beta-lactamase-1 bacteria (NDM-1**) is **highly resistant and there are limited treatment options.** The institute warned last year that the spread of micro-organisms carrying NDM-1 had become a major **global health problem**. Particularly vulnerable are **hospital patients, especially those with low immune systems and medical staff treating them. Symptoms include bacterial-induced septicaemia, with patients developing abscesses, organ failure and pneumonia.**

ADDENDUM:

Financial Mail Cover Story The House that Gore Built
Stephen Cranston: The Financial Mail, 21 September 2012

The right prescription
Twenty years ago Adrian Gore and Barry Swartzberg, (both actuaries) left Liberty Life to form Discovery Holdings. "Medical aid was not a happy industry at the time," says Gore.

In 1992 Gore got backing for his plans from Rand Merchant Bank (RMB) and the bank became Discovery's first client. Initially Discovery was forced to specialise in health as it could not compete with the core Momentum business. In 2000, when it launched its life business, it was prohibited from selling its savings and investment business: instead **it had to focus on risk products such as death, disability and critical illness**.

Herschel Mayers, CEO of both Discovery Life and PruProtect, says that proved to be a blessing as **Discovery Life, unlike its competitors, was focused entirely on the retail risk market**, and it unbundled pure risk cover from the universal life product - a hybrid of risk and investment which dominated the life insurance market in the 1980's and 1990's.

Discovery Life also marketed **a new range of dread disease and disability products**, among them occupational disability and **dread disease** (going beyond the list of 10 tightly defined conditions).

The **Vitality programme provided a competitive edge for Discovery**, as it was able to offer lower premiums and cash back after five years to clients with a high Vitality status.

Since 2007, when the restriction against selling investment products fell away, Discovery **has extended into both savings**, through **Discovery Invest**, and **short-term insurance**, through **Discovery Insure**. Discovery has also launched some successful funds, in which the assets are managed by Investec, and came out with innovative structured products in partnership with Deutsche Securities.

Another tool is the **discount of up to 50% on fuel through its Vitality Drive product**.

Now that FirstRand is a pure banking business, Discovery's shareholder of reference is RMI Holdings, **unbundled last year from RMB Holdings**, which has three underlying businesses: **Discovery, Momentum and Outsurance.**

The house that Gore built has a distinct culture based on a high level of management shareholding, high-advice products and a love of gimmicks and gadgets. It prides itself on being quick to market, rolling out new products from conception in less than a year. **The core team is homogeneous, predominantly made up of actuaries who also worship at the same synagogues at the weekend**.

Swartzberg says Discovery's success lies in the combined strength of the team.

Vitality has proved to be the common denominator; the essential elements are common to its businesses in SA, the UK, China and the US - where Vitality remains even though Destiny Health has been closed.

Unlike Momentum and Liberty, Discovery has no plans to open up in the rest of Africa.

There is no doubt that Gore's greatest contribution was that eureka moment when he dreamt up Vitality. It is what brought companies of the stature of Ping An and Prudential to Discovery's doors.

Growing abroad with Vitality
When Discovery entered the US market in 2001, the prospects looked encouraging. Like Discovery medical aid in SA, its Chicago-based subsidiary Destiny covered almost everything. But Destiny is, to date, **Discovery's only significant failure**. Gore says lessons learnt in the US were applied to subsequent international forays. "One was that we **needed a blue-**

chip partner in each country: Prudential in the UK and Ping An in China, who approached us to partner them."
Acquiring Standard Life Healthcare (SLH) two years ago has put Discovery in **a powerful position in the UK's** relatively small private healthcare system. After the acquisition, the call centre business, which in PruHealth was run from Sandton, was consolidated into the Standard Life offices in Bournemouth.

SLH was mostly in the retail market and PruHealth is now 20% corporate, 40% small business and 40% individuals.
There **are no plans to expand into the rest of Europe** but PruHealth is looking at building an **expatriate health insurance programme for Britons working abroad**.

PruProtect was launched in 2007, once Prudential had decided it was not interested in going into the pure protection business. Mayers says the UK insurance market is conservative and reluctant to embrace new ideas, which gave Discovery the opportunity to shake up the system. **PruProtect introduced a high-advice model**, which appealed to brokers and financial advisers. It has **developed a franchise model** to build its national distribution, accounting for 67% of sales.

PruProtect and PruHealth save costs as they can share common areas such as human resources, finance, compliance and actuarial functions. The common factor of the Vitality programme helps both businesses to grow. In the year to June 2012, the **combined total premium for the businesses was R5-bn.**
Discovery also agreed to take a stake and **reshape China's Ping An Health** into a business with all the familiar characteristics such as Vitality.

Cow with plenty of milk
Discovery Health is no longer the biggest contributor to profit **- Discovery Life's profits are about 20% larger.** But **Discovery Health is the main cash generator in the group.**

Discovery Health Medical Scheme (DHMS) is, after all, by far the **largest open medical scheme in SA**. Most people do not realise that there are **two administrators, Medscheme and Metropolitan Health** which have **more lives under administration.** Both of these operate under a range of brands, **Medscheme through Bonitas and Fedhealth**, and **Metropolitan as Momentum** in the open scheme market.

Discovery's membership has increased by 467 000 from the beginning of 2007 to September 2011 while the rest of the open schemes have lost 845 000 members - the other big beneficiary being Gems.

* Discovery premiums have gone up well above inflation, but at 2,9% above CPI over five years it is well below the 4,8% average for the largest open schemes.

Old Mutual has exited medical aid, after an expensive and **disastrous attempt** to unseat Discovery through its Oxygen product. Sanlam has struggled to get scale. Liberty has had reasonable success, in SA and the rest of Africa.

DHMS has a young age profile, with an average of 31,8, three years below average.

Discovery Health MD Jonathan Broomberg says there are certainly benefits of scale when it comes to negotiating with providers. DHMS pays 91% of specialist and 87% of GP consultations directly. Because of the single exit price legislation, Discovery **cannot negotiate its own drug prices but it has negotiated prices down on behalf of the entire private sector**.

Discovery is pioneering greater use of **electronic health records**, to make health delivery speedier and more accurate. The **Health ID has sold 1 440 special iPads to doctors**.

One of the outcomes of a successful launch of the NHI scheme could be that **patients go to the state for their primary care**. In those circumstances **Discovery could start to look more like its British sister company PruHealth**, focusing on larger, much less frequent, medical events.

Staying alive is no joke

"Vitality shouldn't be seen as a loyalty programme," says Gido Novick, Vitality's CEO, experienced marketer and former CEO of kulula.com. "Its aim is to make **meaningful lifestyle interventions** which will **benefit the health of our members as well as the financial health of the Discovery group**."

For regulatory reasons Vitality is a separate business outside the Discovery Health Medical Scheme. **It made just R5m in the year to June 2012 (down 72%)** but the period was nonetheless considered a successful one for Vitality - not least because of the **further rollout of the Pick n Pay Healthy Foods benefit**, now used by almost as many people as are members of Virgin Active and Planet Fitness gyms. .

Discovery accounts for **60% of the membership of Virgin Active**, and 500 000 Discovery members regularly attend gym. By encouraging physical exercise and healthy eating it is reducing the number of claims for both the health and the life businesses.

Vitality is probably the most exportable part of the Discovery group. The healthy food benefit is available to PruHealth members in the UK through Sainsbury's and in China through Tesco.