HEALTH NEWS HIGHLIGHTS: 2012

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1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

1.1. Funding NHI

The latest on funding proposals: (November) The Treasury expects to publish its delayed discussion document on financing options for NHI before next year's February budget. The Treasury has previously said it is considering a payroll tax, higher value-added tax, or a surcharge on income tax and/or combinations of the above mentioned proposals.

The Department of Health's (DoH) R27,56-bn budget for 2012 was increased by R500-m, of which R366-m was earmarked for conditional grants for infrastructure. Funding for HIV/AIDS programmes would be increased in next year's budget to compensate for the withdrawal of support from the US President's emergency plan for AIDS relief.

Decline in spending: In November it was reported that State spending on health as a percentage of gross domestic product (GDP) would decline from 4,1% in 2011-'12 to 3,95% in 2013-'14; at a time when more money was required to prepare for the NHI scheme, according to Human Sciences Research Council. An additional R6-bn would be needed in 2014-'15 but this was not provided for in the policy statement. Budget allocations to the NHI conditional grant, established in April, were too small to allow for testing various components of NHI as intended.

Funding fears: In February Health Minister Aaron Motsoaledi outlined various projects that the DoH were pursuing: a R1,2-bn plan to upgrade and expand the country's nursing colleges; a scheme to increase the number of doctors that the country produced; regulatory measures to improve the functioning of the health system; etc. However, he shied away from questions on how the state would pay for NHI. These questions about funding have yet to be answered.

1.2. Private cooperation in implementing NHI

Historic Pact: In November *Business Day* reported that Min. Motsoaledi had signed a "social pact" with the private sector, describing it as a historic step towards closer collaboration between Government and private enterprise. The Minister and the CEOs of 23 companies have agreed to meet twice a year to discuss issues that affect them, and have established the Public Health Enhancement Fund to address the skills' shortages facing the healthcare sector. The fund pools donations from 23 companies from the pharmaceutical, private hospital and medical scheme administration industries, who have committed to providing financial support for the next three years. The money will be used to train more doctors, improve the skills of healthcare managers, and ensure specialised training in HIV/AIDS for more doctors. R40-m was committed for the first year.

Clicks: In November the pharmacy division of Clicks formed a public-private partnership with the Western Cape government to provide vaccines and family planning services next year. This includes providing babies with government-procured vaccines and family planning services.

BHP Billiton has donated R200-m 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.

Threats: According to a survey conducted by PPS, a financial services provider focused on graduated health professionals, more than half of the 800 professionals interviewed, agreed with the principle behind the NHI, but only 18% believed it is the solution to the struggling health system.

1.3. Legislation, Plans and Problems

National Health Amendment Bill: In February, the Minister of Health, Aaron Motsoaledi, described this as revolutionary legislation because it would "change the way South Africans see the public health system". The bill provides for an Office of Health Standards Compliance (OHSC), soon to be established. OHSC officials would inspect all public health institutions. Institutions not meeting the standards will receive a notice of non-compliance and could be fined or prosecuted.

Pilot projects: The 10 pilot sites for the NHI pilot project were announced earlier in the year. The sites - which cover 20% of SA's population - are being funded by a R1-bn conditional grant announced by Finance Minister Pravin Gordhan. The European Union donated an additional R1,26-bn. A total of R150-m was allocated for the 2012-'13 fiscal year. The districts are: OR Tambo in the Eastern Cape, Vhembe in Limpopo, Gert Sibande in Mpumalanga, Pixley ka Seme in the Northern Cape, Eden in the Western Cape, Dr Kenneth Kaunda in North West, Thabo Mofutsanyana in the Free State, Tshwane in Gauteng, and uMzinyathi and uMgungundlovu in KwaZulu-Natal.

Despite Motsoaledi's harsh words for the private sector, private healthcare practitioners (doctors and specialists) were contracted to improve service delivery. They are paid by the DoH for working "at least three or four hours" a week in a local clinic.

Doctors: The SA Medical Association (SAMA) believed doctor shortages to be "one of the major issues" standing in the way of NHI. 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.

Trevor Manual's New Development Plan (NDP): Building an NHI system is among the objectives contained in the NDP that was presented to Pres. Zuma in August. The 20-year plan names 4 prerequisites for the NHI to be successful: improving the quality of public healthcare, lowering the cost of private care, recruiting more professionals in both the public and private sectors, and developing health information systems that span public and private health providers.

Five important areas in the public sector according to Min. Motsoaledi: Infrastructure, human resources, quality of healthcare, re-engineering the public healthcare system (deployment of retired nurses, school health programmes); and deployment of teams of specialists and nurses to the health districts, especially in rural areas.

More hurdles: According to health experts SA medical professionals are flooding foreign markets while 452 government hospitals are on the brink of collapse; the public health sector has a total of 44 780 vacant posts for professional nurses and 10 860 for doctors; pharmaceutical companies are complaining about the backlog in the registration of products at the MCC while a shortage of an essential AIDS drug reveals shortcomings in the DoH's medicines supply chain management.

1.4. General News

Vaccination: The DoH has acknowledged it did not know how many babies were unvaccinated because it had only a hazy idea of the size of the population it was targeting. According to department figures there was a 95,1% coverage rate, however the figure from World Health Organisation (WHO) and United Nations Children's Fund (Unicef), was only 72%.

Academy: From January 2013 new hospital CEOs and other high-level managers responsible for healthcare delivery in SA will undergo specialised training in healthcare management at the new Academy for Leadership and Management in Health. The first students will be the new CEOs of the 97 hospitals located in 8 provinces, with the exception of the Western Cape.

Corruption: According to the CFG Research Institute (March) an estimated R30-bn had been lost annually due to incompetence and negligence in the public service. Research by Fight against Corruption, found that 600 000 low cost houses, 60 hospitals with a 280 bed capacity each, 3 000 rural clinics and 915 schools could be built with the R30-bn estimated to have been misappropriated from state coffers. From September 2004 to June 2011, the National Anti-Corruption Forum formally charged over 1 273 public service officials with misconduct for corrupt activities: 603 officials have been dismissed from public service, 226 suspended, 134 fined and 16 demoted.

Pensioners: The introduction of the NHI could mean that all pensioners would be better off in retirement, depending on their level of income, with middle-income earners likely to be the biggest beneficiaries. NHI will also benefit pensioners losing their company's contribution after retirement.

1.5. Comments on NHI

Ames Dhai (Director of the Steve Biko Centre for Bioethics at Wits): At a NHI Conference in April views expressed by members of the World Bank, the WHO and leading health economists in the country were that the financing of NHI is not beyond the reach of SA. However, the country lacked efficient management and use of the funds coupled with the elimination of corruption.

Business Day, (16 August): "If Government continues to regulate private healthcare, it needs to set up a credible and independent institution to do so. But, if the goal of a healthcare pricing commission is to set prices based on some 'socialist fantasy of cheap, quality and affordable healthcare for all', rather than input costs, Health Minister Aaron Motsoaledi may as well 'move his office into the high court'."

Dr Chris Archer (CEO of SAPPF): NHI is "the wrong cure for a misdiagnosed problem". The public healthcare system needed "rehabilitation" based on its effectiveness in comparison with the amount of money allocated to it, meaning "political considerations are taking precedence over economic reality". NHI, which was "a funding mechanism", and could not deal with the problem of poor delivery. He also defended the cost of private healthcare, saying it was of high quality and, when looked at from an international perspective, was very affordable.

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

Prof Gavin Mooney (CEO of Africa at Work, a consulting company focusing on African business): "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."

Medical Chronical survey: According to a survey the majority of SA's doctors believe the country's healthcare system does not have a bright future, but many are willing to help improve it. Most practitioners (56%) who responded did not support Government's concept of NHI. They feel strongly that the focus should be on fixing up state facilities that are largely ineffective. Only 12,4% agreed with the statement that SA health had a bright future. The majority indicated that they were likely to stay in the country. Medical schemes were seen in a negative light by practitioners, who indicated that they were unconvinced that the schemes had members' interests at heart.

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

2.1. HIV/AIDS and Tuberculosis

South Africa: SA is said to have the largest antiretroviral (ARV) therapy programme in the world.

Government's HIV/AIDS programme: Pali Lehohla, Statistics SA's statistician-general, said it looked as though SA had turned the corner, probably, in the face of availability of ARVs. However, it was hard to state

that AIDS was the cause of the majority of deaths prior to 2006 because it was not a notifiable cause of death in SA.

In November UNAIDS praised SA for "increasing its HIV treatment by 75% in the last two years". About 1,7-m of the 5,1-m HIV-positive South Africans now have access to ARVs. In 2011 SA had 100 000 fewer deaths from HIV compared with 2010.

According to an article in *The Southern African Journal*, the number of patients receiving ART in SA by the middle of 2011 had increased to 1,79-m. This was well in excess of the 80% target of patients who were eligible for ART. The majority (61%) of patients were women aged 15 or older; men accounted for 31%; and children below the age of 15 for 8 %.

Treasury data revealed that total spending on HIV was R16,9-bn for 2010/11, of which R5-bn was from donors.

3-in-1 pill: Mylan Pharmaceuticals - which manufactures a 3-in-1 ARV pill - will tender for a contract to supply the DoH after an agreement with Aspen Pharmacare.

Males on HIV treatment are almost a third more likely to die than females because they access ARVs at a later stage of their disease than women, making them more vulnerable to death.

Financing: SA is preparing for a "50% or more" cut to funding from the US government for HIV/AIDS programmes over the next five years. The cut is due to the Obama administration's decision to scale down its support for global HIV/AIDS programmes.

Tuberculosis (TB): is the number one killer of the black population in South Africa, according to Statistics SA's November 2010 report. HIV often distorts the normal manifestation of TB, making it hard to diagnose and treat.

MDR TB: Research published in the *Lancet* medical journal in August 2012 suggested that MDR TB was becoming increasingly prevalent in Africa, Asia, Latin America, and parts of Europe. MDR TB was 200 times more costly to treat than TB, and had severe side effects. Of the 336 000 new active disease cases notified in 2010, about 2% was MDR-TB, and about 10% of those, XDR-TB.

Mineworkers: TB might be spreading like wildfire as mine strikes worsen. According to a Chamber of Mines review TB incidence is 15 times higher among gold miners than among the general population. Defaulting on TB treatment increases the chance of relapse; and developing resistance to the drugs used. In the past the TB epidemic was often concealed by HIV/AIDS. At least three out of five TB patients are also HIV-positive; fighting two infections at once.

Other countries: According to the annual report of the Joint United Nations Programme on HIV/AIDS low- and middle-income countries have doubled spending on Aids to $8,6-bn (R76-bn) since 2005, compared with international funding for the disease that stalled at $8,2bn last year.

The virus is still spreading in the Middle East, North Africa, Eastern Europe and central Asia.

UNAIDS' latest statistics revealed that more than 2,5-m people worldwide were infected with the virus last year. Of the 34-m people living with HIV, about half did not know their HIV status.

The number of children in the world infected with HIV decreased by 26% between 2009 and 2011.

Research and medication: In October Dr Glenda Gray, SA co-principal investigator for the HIV Vaccine Clinical Trials Network, said results of the RV144 Rhai study in Thailand gave hope for a vaccine to prevent HIV infection. The vaccine had a 31% efficacy during trials. If the SA trial was successful, SA would be the first country where the vaccine would be licensed.

Scientists from the Centre for the AIDS Programme of Research in SA had found that the immune systems of two women living with the HI-virus were able to produce antibodies which could neutralise and kill 88% of the virus. Researchers hoped they could use this information to develop a vaccine that would prompt the body's immune system to make broadly neutralising antibodies.

Diagnostic device: A new diagnostic device can be used to test patients for TB, including drug-resistant TB, in just 100 minutes. It is now available in 67 low- and middle-income countries.

NC1: A New TB drug combination could cure TB in a record time (4 months) and cut treatment costs by 90%. The New Combination 1 (NC1) study is done at the University of Stellenbosch.

2.2. Cancer and other non-communicable diseases

Non-communicable diseases are chronic diseases, including heart diseases and cancer.

The SA phase of the Lilly NCD partnership, a US$30-m global project involving SA, Mexico, Brazil and India, will tackle the scourge of non-communicable diseases (NCDs), paying particular attention to diabetes. The project aims to make direct contact with patients (especially in rural areas) at primary healthcare clinic level.

Around 2 500 SA children develop cancer every year, but less than a third are actually diagnosed and treated.

Five steps: could reduce deaths from cancer in SA, according to the Cancer Association's head of research, Dr Carl Albrecht. They are: vaccinate all 10-year-old girls against human papilloma virus (HPV); gather accurate information on cancer prevalence, incidence and tendencies; modernise equipment; create a cancer council to co-ordinate cancer-fighting efforts; and use tax (R8-bn is raised in tobacco taxes every year) for health promotions.

Bad news: Medicine stock-outs, broken machinery and poor hospital administration are hindering access to treatment that determines whether public sector patients live or die. Considering that SA had the largest health budget in Africa, this was deplorable, said the Cancer Alliance.

Obesity: According to an ongoing study at North West University on 14-year-olds (256 adolescents) teens are right up there with their US and UK counterparts when it comes to being overweight. Research also showed that being inactive not only affected health later in life, but could also lead to poor academic performance.

The latest WHO statistics revealed that the percentage of Americans who are obese - those with a BMI of 30 or higher - has tripled since 1960 to 34%, while the incidence of extreme or "morbid" obesity (BMI above 40) has risen six-fold to 6%.

2.3. Malaria

Poor quality of medicine: Large parts of Africa are threatened by the distribution of fake and poor quality anti-malarials made illicitly in China. Parasites that survive the drugs may become resistant to it and spread a form of the disease that ACTs (artemisinin combination therapy) will no longer cure. According to the *Malaria Journal*, some of the fake anti-malarials on sale in Africa are equally useless and dangerous because they are of poor quality.

Resistance: Malaria-carrying mosquitoes in Africa and India are becoming resistant to insecticides. While prevention measures such as mosquito nets treated with insecticide and indoor spraying are still effective, experts said tight surveillance and rapid response strategies were needed to prevent more resistance developing. According to the WHO resistance had been detected in 64 countries.

3. DOCTORS, NURSES, HOSPITALS & TRAINING:

3.1. National Department of Health

"SA health system still stuck in Polokwane," reads an article in *Business Day* (12 December).

Five years ago the ANC agreed on a list of measures to improve SA's health system at its Polokwane conference. Progress made in implementing the 17 health resolutions has been sketchy.

Now it seems unlikely that there would be anything new on NHI at Mangaung," said Peter Attard Montalto, an emerging markets economist with Japanese securities firm Nomura.

Although progress in implementing the NHI is impossible without a proper funding plan, Treasury is only expected to publish a discussion document on funding options next year.

Meanwhile the health system has virtually collapsed in many parts of the country. Government has also failed to establish a pharmaco-vigilance centre for monitoring adverse events from AIDS drugs, and weaknesses in the drug supply chain mean patients periodically fail to get their medication, putting them at risk of drug resistance. Cancer patients continue to face drug shortages and equipment failures that put their lives at stake. There has also been no progress on the much-publicised decision to overhaul academic hospitals such as Chris Hani Baragwanath via public-private-partnerships. The limited effect of the ANC's Polokwane health resolutions should come as no surprise, says political analyst Steven Friedman: The ANC might be the governing party, but that did not mean resolutions translated into policy.

The downward spiral in the public healthcare system seems to continue, although there are pockets of excellence, providing the hope that it is still possible to arrest the slide - **Editorial Comment, *Business Day*,** 12 December. "A lot of effort has been put into correcting this since Dr Aaron Motsoaledi took over as Health Minister, but surveys and anecdotal observation reveal that success has been patchy. The injection of additional funds into the NHI pilot sites appears to have resulted in a marked improvement in the facilities and quality of services and management. But extrapolating this on a national scale implies an astronomical sum, which will not be feasible in the foreseeable future ... Meanwhile, the fees charged by public hospitals have risen rapidly ... As much as 6-m South Africans can neither afford private medical aid nor earn enough

to pay the debts they accrue to the state for basic healthcare."

According to an article by CGF Research Institute in March this year an estimated R30-bn is lost annually by SA taxpayers due to graft, incompetence and negligence in the public service.

The bankruptcy of some of the provinces and municipalities has been caused mostly through corruption, maladministration, tenderpreneurship, nepotism and cronyism. Over the periods September 2004 to June 2011, the National Anti-Corruption Forum formally charged over 1 273 public service officials with misconduct for corrupt activities; 603 officials have been dismissed from public service; 226 suspended; 134 fined; and 16 demoted.

Editorial Comment on public hospitals (*The Times,* September): "As thousands of patients die, waiting for life-saving treatment, several provinces are sitting on a staggering R800-m earmarked for improving healthcare. Min. Motsoaledi revealed in parliament that five provinces had underspent their allocations for the hospital revitalisation programme by almost R2-bn: Eastern Cape: R191-m; KwaZulu-Natal: R228-m; Free State: R134-m; Limpopo R89-m; and Northern Cape: R158-m. This was ascribed to delays in awarding tenders, rolling-over of budgets from the previous financial year, poor performance by contractors, termination of contracts and court challenges.

3.2. Provincial Hospitals

The downward spiral in Gauteng's public healthcare system is best noticed in the deteriorating service and conditions in provincial hospitals. In rural clinics conditions are even worse.

Doctors and nurses work long hours as vacancies are not filled. They are exposed to patients dying due to a lack of medicine or proper equipment; have to cope with overcrowding, long queues and waiting lists, filthy and unhygienic conditions, power outages and not getting paid for working overtime. To top it all, provincial hospitals are the victims of corruption, nepotism and bad management. Written complaints by senior doctors seem to have fallen on deaf ears.

A FEW EXAMPLES

Gauteng: In December Gauteng premier Nomvula Mokonyane admitted - after months of excuses - that the Gauteng health department had lost control of its finances. The provincial treasury will step in to clean up the mess and an administrator will be appointed by the end of December. The health department's struggle for years to manage its finances resulted in patients dying while waiting for essential treatment. In an interim report in August the Special Investigating Unit recommended that R16,5-m be recouped from corrupt former senior Gauteng health officials. Mokonyane admitted the department owed money to 883 suppliers.

Gauteng health department was allocated R13,18-bn for salaries in the 2011-2012 financial year, but spent an estimated R14,22-bn. In June it was reported that the department paid about R90-m of its salary bill for its 180 deputy directors, claiming they help to improve the system.

R1,3-bn was spent to clear the debt owed by the medical supply depot.

In September Gauteng's head of health, Nomonde Xundu, admitted in parliament that many of the

province's revitalisation projects were behind schedule and over budget. She has since resigned.

In November the Gauteng DoH was granted a R2,4-bn bailout to sort out the provision of healthcare in hospitals, clinics and other health facilities.

The department has been delaying the announcement of findings of a forensic investigation into suspected financial irregularities at the medicines supplies depot in Auckland Park.

Gauteng's three most important hospitals: Charlotte Maxete, Steve Bico Academic, and Chris Hani Baragwanath were reported to be in very bad shape. A chronic shortage of life-saving equipment and exhausted and overburdened medical staff; poor supply-chain management at provincial level and non-payment of suppliers are but a few of the problems. In December 1 319 patients were on waiting lists for operations at Charlotte Maxete.

The Public Protector launched an investigating into the shocking treatment of babies and children in public hospitals after reports on the shortage of beds for critically ill children in ICUs as doctors were forced to "play God" daily in deciding which children got a bed in an ICU and which were sent to a general ward.

Corruption: Charges against several senior officials in the Gauteng health department for unauthorised expenditure of more than R1-bn had been referred to the Anti-Corruption Task Team. An interim report identified 10 procurement matters worth more than R1-bn for investigation, and recommended the recovery of about R11-m in duplicate payments made to one service provider. R1,1-bn is owed in outstanding patient fees.

Limpopo: In this province the public healthcare system is even worse off than in Gauteng. The province had to be put under administration due to its financial problems. According to a report compiled by the Auditor General in March 2011 the Limpopo health department blew R400-m on irregular expenditure and could not show who was to receive about R2,8-bn which it had committed to paying for contracts. It also revealed collapsed or non-existent controls involving millions of rand, and a flagrant disregard for financial management, public finance laws and legal obligations.

The cash-strapped Limpopo faced a potential health crisis after over-stocked medicines, acquired for R34-m, expired while some were allegedly looted or sold by corrupt officials. Boxes of expired medicines - including antibiotics, ARV's and HIV test kits - were dumped outside Polokwane.

Meanwhile the province's 46 hospitals and more than 360 clinics had run out of medicines.

Eastern Cape: Public health services in this province are in shambles and the province is maybe the worst hit by bad management and corruption. This province had also been put under administration. In March it was reported that the health department needs an extra R9-bn to fill its 27 267 vacant health posts. By June dozens of doctors and thousands of community healthcare workers had not been paid; some for as long as six months.

Western Cape: One in five patients treated at some state hospitals in the Western Cape are from other provinces or countries, according to a report early in the year. DA Premier Helen Zille said the health system in the province was "functional and delivering quality care to patients" due to strong leadership, strict control and fiscal discipline.
According to Econex research the Western Cape's doctor-to-population ratio was 135 doctors per 100 000

people - the healthiest ratio in South Africa. This is followed by Gauteng with 102 doctors per 100 000 people and the Free State with 55 per 100 000 people.

However, a senior Cape Town doctor has lifted the lid on conditions at the city's Eerste River Hospital, saying doctors and nurses at the hospital felt trapped and were being bullied by managers. The Auditor General's latest report also revealed an increase in cases of corruption, nepotism, fraud, financial and human resource irregularities at the department.

Mpumalanga: In November, after a DA complaint about the state of 32 hospitals in Mpumalanga, an investigation was launched by the SA Human Rights Commission (SAHRC). Min. Motsoaledi said the health department's extensive failings were because of mismanagement, not a shortage of money. Among the problems were pilferage, theft, corruption, expired medicines and poor logistics.

3.3. Private versus Public Healthcare

In its editorial comment, *The Star,* 17 April, Garth Zietsman quoted Min. Motsoaledi, predicting that due to escalating costs, private medical schemes will no longer exist in a decade or so.

Economist Mike Schussler compiled statistics from independent sources such as Statistics SA, the National Treasury and the Council for Medical Schemes reports. According to Schussler almost 100% of the cost in private hospitals care is borne by the client, whereas only 2% of the cost of public hospitals' 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, said Schussler. As this payment was channelled via Government, instead of paid directly to the hospital, a significant portion was diverted into Government itself to cover administration and the like. In other words, Government funding figures will underestimate the actual cost of public hospitals to taxpayers. The declining public admission rate per capita proves that **Government's healthcare policy leads to less care for the poor according to Schussler.**

Although Min. Motsoaledi's attitude towards the private health sector is perceived to be very negative, he had to admit that the implementing of NHI will not succeed unless the private sector shares its know-how with the public sector.

In November the Minister and the CEOs of 23 companies established the Public Health Enhancement Fund to address the skills shortages facing the healthcare sector. In the next three years donations from the 23 companies from the pharmaceutical, private hospital and medical scheme administration industries will be used to train more doctors, improve the skills of healthcare managers, and ensure more doctors get specialised training in HIV/AIDS programmes.

3.4. Doctors, Dentists and Nurses

Doctors: Universal healthcare coverage in SA is threatened by the rate of the brain drain among doctors, according to Econex director Cobus Venter. SA had enough financial capacity to sustain its doctors, while importing foreign doctors was costing the country more, he said. Doctors left because of uncertainty and poor working conditions and not because of financial reasons. Although universities have all increased their intake of students, it is not enough when considered that 50% of doctors leave the country within 5 years.

Practitioners registered with HPCSA fell from 168 160 in 2011 to 165 371 in March 2012. Doctors in the private sector have agreed to contribute their skills (4 hours a day) to public healthcare, and in particular to the NHI pilot programme.

Dentists: According to the SA Dental Association (SADA), there are less than 3 500 practising dentists in the country. This meant 5,63 dentists per 10 000 people who can access private dental care and 0,2 dentists per 10 000 people in the public sector. Medical schemes have been criticised for adjusting their benefit structures and paying less for dental procedures.

Nurses: The average nurse working in SA's public service – whether it be in a rural clinic, hospital or in one of the big provincial hospitals – seems to be working long hours in overcrowded, filthy, unhygienic conditions, trying to cope without the necessary equipment and medicine and exposed to HIV/AIDS and TB. According to research by Econex and based on the future supply scenario models, there were 189 718 nurses actively working in SA in 2010; 111 180 nurses were working in the public sector in 2010 and 78 538 in the private sector. Of them 25 392 nurses were working in private hospitals and clinics. This implies that 53 146 nurses were working in the private sector.

3.5. Training

Thousands of matriculants with straight-A's aspire to get into medical school - but admission is uncertain even among the brightest. In the beginning of this year there were approximately 6 000 applications for 250 slots in first year medicine at Wits; at Pretoria University 11 000 for 240 places; UCT had 4 400 applications for 220 and Stellenbosch 1 800 applications for 230 places.

In August, findings published in the *SA Journal of Medicine*, highlighted the lack of supervision and training as well as inadequate surgical experience of ear, nose and throat (ENT) surgeons.

Universities and teaching hospitals did not ensure adequate teaching facilities, according to the study. At three out of the seven institutions, registrars were exposed to less than three quarters of the surgical procedures required by the College of Medicine of SA. Prof Dan Ncayiyana, editor of the *SA Medical Journal* said the problem lay with the teaching hospitals. However, SA still produced the best specialists who were in demand all over the world.

Earlier in the year Min Motsoaledi announced that academic hospitals will be controlled by the national department by next year.

Training in Cuba and Cuban doctors: Government signed an agreement with Cuba, increasing the number of SA medical students training on the island (1 000 SA students started their training in September) and bringing more Cuban-qualified doctors to work in SA. Cuba will provide 208 specialists for district-based support teams in the pilot phase of the NHI.

Nurses: The SA Nursing Council and Africa Health Placements agreed to work together to bring more nurses to SA to solve the shortage of nurses, especially in rural areas - served by only 19% of the country's nurses.

Grants: Nursing colleges were promised a grant for R100-m from **t**he National Nursing Colleges and Schools Grant, which totals R100-m for 2012-'13.

4. MEDICAL SCHEMES:

4.1. Consolidation of medical schemes

In 2001 South Africa had 146 medical schemes; in 2012 this figure was only 95; and it could become even less as more schemes are expected to merge. The result has been strong growth in open schemes such as Discovery Health, whose market share rose from 16% to 29% over this period, and its restricted counterpart, the Government Employees' Medical Scheme (GEMS), which now accounts for 16% of the market, according to Alexander Forbes Health.

According to **Discovery Health CEO Jonathan Broomberg**, ageing population of medical schemes, improving medical technologies and a rapid increase in chronic diseases all play a role. He expects that in time there will be only between 5 and 10 open schemes in SA.

André Meyer: CEO of Medscheme: Merging two schemes could reduce the cost ratio by 15 % to 25%, resulting in more negotiating power with medical service providers.

Global Credit Ratings: Smaller schemes seem to suffer due to: the ruling on paying PMBs in full; the CMS advising schemes with deteriorating finances to consider amalgamation.

However, the **CMS 2011/12 annual report** noted that, despite their market dominance and the inherent benefits of economies of scale, larger administrators did not appear to offer any cost advantages over their smaller rivals. Discovery spent on average R103,60 per beneficiary per month on administration, while the industry average was R89,10.

Discovery/Transmed saga: Since Transmed's decision to close a low-cost option Ubuntu, a flood of older Transmed members has applied to join Discovery's low-cost KeyCare plans. Discovery is of the view that it is being forced to take on the Transmed members after both Discovery and the GEMS declined offers to merge with Transmed. The Appeal Committee dismissed the argument that the alleged conspiracy posed a systemic risk to the scheme as an influx of Transmed members posed a risk and liability to the scheme and its current members.

GEMS: Earlier in the year the independent appeals board ruled that GEMS must comply with legislation and accept any and all individuals or groups that wished to join the scheme, as long as they were Government employees or a public entity or previously employed by these organs.

4.2. NHI and Medical schemes

Board of Healthcare Funders (BHF): In its submission to the government's Green Paper on NHI, the BHF emphasised that the private healthcare sector's expertise and sophisticated infrastructure could be utilised in the NHI. The private sector needed to reform in order to align with national health policy and ensure a seamless integration of the 8,5m medical scheme members into the NHI.

Medical schemes: Although medical schemes declared their willingness to cooperate, some schemes seemed to doubt the success of government's ambitious NHI and believe the provision of healthcare in the country is deteriorating.

A PriceWaterhouseCoopers (PwC) survey, titled *Strategic and Emerging Issues in the Medical Scheme Industry,* shows that schemes believe the NHI alone is not the solution to SA's healthcare problems. The demarcation between health insurance and medical scheme cover and new regulations from the CMS, also resulted in negativity. Respondents believed better working conditions and an overhaul of basic resources were needed before NHI could be implemented. Although the majority of them believed that NHI would increase access to healthcare for previously disadvantaged people, they did not foresee it reducing the cost, or resulting in the better use of funds allocated to healthcare. Most of the respondents think the pending Medical Schemes Amendment Bill will only cause a further regulatory burden.

4.3. Tariffs: higher tariffs, less benefits and guidelines

No guidelines: The expanding spiral in the cost of healthcare provision can be dated back to the scrapping of the tariff price list for healthcare services. Before 2004, the schemes and the various groupings such as hospitals, specialists and doctors used to negotiate tariffs together, while schemes did this collectively on behalf of their members. The Competition Commission (CC) ruled this to be collusive behaviour and prohibited that practice. The CMS - and later the DoH - took over the publishing of a tariff, which was seen as merely a guideline and were not agreed to by all parties.

In 2008 the HPCSA scrapped its "ethical tariff" guidelines. These were in effect a set of maximum prices.

In 2010: the National Health Reference Price List was scrapped by the High Court. Since then there has been no tariff in place and prices has skyrocketed.

2012 tariff guidelines: In August the HPCSA announced the publication of its tariff guidelines for medical and dental services causing shock and anger amongst professionals when it was realised that the HPCSA had taken the industry back nearly a decade, to the 2006 NHRPL, but with an inflator of 46,44%. The 2012 tariff guidelines are on average between 30% and 40% lower than the published HPCSA fees for dental practitioners in 2006. In a joint press release by the SAPPF and SAMA and other associations the new tariff guidelines were rejected. The 2012-tariff guidelines have since been withdrawn, pending an inquiry into healthcare costs.

The Competition Commission's inquiry into healthcare costs (announced in August) 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.

All but one of 20 medical schemes surveyed by PwC welcomed the CC’s proposed investigation into private healthcare costs. Medical scheme members and healthcare providers voiced their dissatisfaction with the way schemes have structured members' benefits. Benefits that were cut, included those covering allied and therapeutic healthcare services, which cover psychologists, speech therapists, occupational therapists and home nursing; expensive diagnostic scans, such as those for MRI and CT scans; dentistry; and oncology.

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.

BHF: Price increases in the healthcare sector over the past 10 years amount to about 75% for hospitals and 59% for specialists. In the 2010/11 financial year, 37% of medical aid premiums were paid into hospitals, 22% to specialists, with medicines accounting for 17%. In that year, a total of about R95-bn was collected in premiums.

Non-healthcare benefits include administration, broker fees and CMS levies. Administration costs are regulated, and schemes are not allowed to spend more than about 10% of incoming revenue on non-healthcare costs. Last year R2,11 out of every R100 of a member's contribution was spent on administration. A solvency level of 25% also has to be maintained, according to law.

2013 tariffs: Some medical schemes have failed to implement the price recommendations of the CMS because healthcare costs tend to rise faster than the consumer price index (CPI) Some of the tariff increases for 2013 are: Discovery: 10,9%; Profmed: 8,56%; Momentum Health, 7,9%; Medshield Medical Scheme, 7,5%; Topmed: 9,47%, Compcare: 6,9%; Pharos: 10,8%; and Fedhealth:7,9% **.**
Claim costs: The average increase in claims costs per beneficiary continued to exceed average CPI inflation (5%) by more than 2,6%, according to the CMS's 2011 annual report. Hospitals: 36,6%; medical specialists: 22,8% of claims; medicines: 16,3%; GPs: 7,3%; and dentists: 3,5%.

Reasons given for higher premiums: Changing of members' profiles: more older people claiming more and using more chronic medicine; expensive new technology; administration fees; medical inflation above CPI; escalating costs of hospitalisation and private healthcare; specialists' costs; PMBs; and the legislated 25% solvency ratio.

Trustees*:* The remuneration of medical scheme trustees has risen by as much as 50% in the past financial year. The highest-paid trustees highlighted in the CMS's annual report were: Liberty (an average of): R703 000; Medshield: R422 000; Spectramed: R380 000; Fedhealth: R297 000: and, Discovery: R257 000.

4.4. The dilemma of Prescribed Minimum Benefits (PMBs)

PMBs comprise a basket of 272 hospital-based conditions, 25 chronic conditions and emergency care. These benefits are the main drivers of this part of the medical aid premium allocation.

At the heart of the legal row is a dispute between the BHF and the CMS over the extent to which medical schemes should reimburse members' claims for PMBs. BHF, which represents certain medical schemes and their administrators, believes schemes should be able to limit payouts to ensure financial stability.

The CMS, a statutory body that regulates the medical schemes industry, believes schemes should reimburse members in full, at the rate charged by their doctor or hospital, so patients are not left with hefty bills. After attempts to resolve the issue failed, the board turned to the courts, asking for a declaratory order to clarify the meaning of regulation 8. The board was joined by Samwumed medical scheme, and opposed by the council and 12 other parties including the Health Minister, the Hospital Association of SA, and the South African Private Practitioners' Forum (SAPPF).

The latest: In September 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 PMB claims at full cost. The court did not give reasons for its decision. Medical schemes supporting the BHF said this interpretation of the regulation gave providers a blank cheque to charge as

much as they like for PMB services.

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.

4.5. Doing away with health insurance products

Government's announcement of draft Demarcation Regulations in April, (to find a better balance between medical schemes and health insurance products; and address the risk of possible harm caused by health insurance products) caused a very negative response as it implies doing away with health insurance products. Government fears gap cover might lead to the young and healthy (usually cross-subsidising older, sicker individuals) buying down to less comprehensive options in a medical scheme and purchasing gap cover to make up the difference.

These include gap cover, top-up cover operating on the basis that the policy holder pays a premium that is not determined by the policy holder's age, health status or income.

The need for, and increase in, top-up and gap cover has been driven by medical scheme benefits decreasing and by the remaining benefits becoming increasingly unaffordable.

4.6. Fraud puts added pressure on system

The fact that SA did not have a proper, functioning national health technology assessment institution that provided guidelines, created more opportunities for fraud.

According to a **KPMG study,** code manipulation and claiming for services not rendered accounted for 76,2% of fraud committed by service providers in the healthcare industry. Collusion between member and service provider was a primary cause for fraud, followed by member apathy, ignorance, and a lenient approach by regulatory bodies.

Michelle David, a medical scheme specialist at law firm Eversheds, said medical aid fraud amounted to about R15-bn annually; much higher than the estimated R4-bn to R5-bn.

Fraud leading to Curatorship: In the past decade, 10 medical schemes have been placed under curatorship after trustees milked their reserves and dished out contracts to friends and family. Among them are Medshield, Sizwe, Bonitas, GenHealth, Medicover 2000, Pro Sano, Protea, Renaissance, and Telemed (all open schemes). Closed medical schemes that are restricted to specific professional groups tend to have very tight oversight, limiting the scope for corruption. The CMS and DoH are planning new amendments to the Medical Schemes Act concerning this matter.

5. PHARMACEUTICALS:

5.1. Pharmaceutical industry in SA

State regulation: In September *Business Day* reported that the DoH has once again refused to bow to calls from pharmaceutical wholesalers for it to protect smaller players in the industry. Government is trying to regulate the logistics fees paid by pharmaceutical manufacturers to wholesalers and distributors to get their medicines to pharmacies and doctors as part of the broad push to control medicine prices and give consumers a better deal. One of the issues facing the wholesale industry is the extent to which Government's latest proposals will enable pharmaceutical companies to negotiate logistics fees below the caps set by Government.

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): no more than 8% plus R3; medicines priced between R100 and R500: 6% plus R4; and above R500 but less than R1 000: 4% plus R5. Medicines priced at R1 000 or higher will have logistics fees capped at R54.

The third Industrial Policy Action Plan will ensure that 70% -80% of Government's procurement of pharmaceuticals should be sourced locally by 2015. The preferential procurement regulations for pharmaceuticals will encourage multinational drug firms to invest in local manufacturing plants. The aim is to stimulate the domestic industry and attract foreign investment, create jobs and ensure sustainability of medicine supplies.

The DoH tender for tablets is to be awarded in favour of companies that produce the drugs locally. The two-year tender, excluding antiretroviral (ARV) and antibiotics medications, is worth R2,5-bn. **Traditional medicine:** The discovery of old notebooks belonging to Norwegian Dr Henrik Blessing, who lived and worked in the now known as KwaZulu-Natal in the 1800's, culminated in the launch of a book detailing the traditional uses of nearly 100 medicinal plants from that region. *SA Traditional Medicinal Plants from KwaZulu-Natal* catalogues traditional uses of the plants and modern scientific records of their effects. Traditional medicines are widely used in SA, with politicians frequently claiming that up to 80% of the population uses them. More than 300 local plants are traded with an economic value of R4-bn a year according to University of the W-Cape.

Slow registration: Pharmaceutical companies complain that the MCC does not use provisions in its own policy guidelines for "abbreviated registration", which recognises work done by regulators such as the US Food and Drug Administration and the European Medicines Authority.

About 1 500 applications were awaiting approval, most of them for generic medicines.

In June, delays led to two companies cancelling contracts worth R9-m. Among the companies complaining about slow registration are: Cipla Medpro, Adcock Ingram, Litha Healthcare Group and Pharma Dynamics. Some of them have been waiting 6 to 8 months for registration.

The SA Health Products Regulatory Authority promised to employ about 400 permanent staff and cut the registration timelines for name-brand drugs to 24; 12 months for generics by 2015.

A Marketing Code Authority has been launched 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.

Complementary medicines could not be included because they were unregulated.

SA's medicine patent laws need strengthening as pharmaceutical firms are "ever-greening" old medicine, thus preventing access to cheaper drugs. Companies often register new patents for old drugs to which minor changes have been made extending their monopoly period on a drug.

5.2. Medicines recalled:

Novartis has recalled the painkiller Excedrin in SA as a precautionary measure following consumer complaints of chipped and broken tablets, inconsistent bottle packaging and line-clearance practices at its Lincoln, Nebraska facility in the US.

Lean Genie's JS Slim slimming capsules and Lifestyle Tradelink's Fruits & Vegetables capsules, sold countrywide as "100% natural" have been found to contain sibutramine and phenolphthalein. Sibutramine is a schedule-five drug and Phenolphthalein could potentially cause cancer in humans.

Aspen Pharmacare had to remove products branded Andosept from shelves after Australian producer Wirra successfully opposed its application for leave to appeal against a ruling in 2011.

5.3. Research and new drugs

Tenders for the triple pill: From April next year SA HIV patients are to get a 3-in-1 pill. The new pill combines tenofovir, emtricitabine and efavirenz, and will cost R89,37 per patient per month, making it the lowest price worldwide. The contract for the triple pill has been split between Aspen Pharmacare (20,6%), Cipla Medpro (almost 25%) and Mylan pharmaceuticals.

Smart pill: Proteus Biomedical designed an edible microchip embedded in a smart pill. Once ingested it enables monitors to know which pills are taken and when they are taken.

Generics: According to the IMS Health 2011 annual report, more than 50% of South Africans now opt to use generic medicines rather than a brand name prescription drug. The actual generics volume sales in 2008 were above 45%.

Branded generics: According to healthcare analysts branded generic are gaining momentum over unbranded and cheaper generics. Unbranded generics were perceived as low quality by consumers.

Biologics: Meanwhile Discovery Health has warned that growing demand for expensive biologic drugs are sharply pushing up its medicines bill.

Cheaper biologics: Biologics could become more affordable and accessible if more of these drugs are distributed to state hospitals. 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% to 50%.

AIDS-drug plant to 'help cut trade deficit': Government's planned joint venture with Swiss pharmaceutical manufacturer Lonza to produce the active ingredient in antiretroviral drugs would narrow SA's growing trade deficit in the pharmaceutical sector. The venture involves Lonza and the SA government's Pelchem - a subsidiary of Necsa based at Pelindaba. The Ketlaphela Project is to begin with antiretrovirals but will move to medicines for other diseases such as TB, malaria and diseases on the African continent. Total investment in the plant was about R1,6-bn.

5.4. Global News

Scientific know-how and donating drugs: The world's major pharmaceutical companies have pledged more than $785-m to support neglected tropical diseases (NTD) research and development (R&D) and strengthen drug distribution and treatment programmes. Among them are Pfizer, Merck, Johnson & Johnson, Sanofi, GlaxoSmithKline and Novartis.

Pharmaceuticals in India: The Indian Patent Office effectively ended Bayer's monopoly for its Nexavar drug and issued its first-ever compulsory license allowing local generic maker Natco Pharma to make and sell the drug cheaply in India. Companies like Pfizer, GlaxoSmithKline and Novartis are eyeing India and emerging markets, like China, as a growth opportunity but worry about intellectual property protection in a country that is also a leading source of cheap copycat medicines.

India’s patents appeal board revoked a patent granted six years ago on Roche's hepatitis C drug Pegasys. The Intellectual Property Appellate Board cited a lack of evidence that the drug was any better than existing treatments and its high price as reasons for the decision.

The risk of inferior/counterfeit drugs: Up to 15% of all drugs tested in African cities and 7% in Indian cities failed basic quality testing, says Roger Bate, author of *Phake: The Deadly World of Falsified and Substandard Medicines.* A study of malaria drugs found up to 40% of those bought in the two largest West African cities had insufficient active ingredients. Some of the drugs might be counterfeits, but many were made by local African, Indian or Chinese companies without the proper oversight of a government drug regulatory authority.

Johnson&Johnson: Generic manufacturers are to be given a free rein to make cheap copies of Johnson & Johnson's HIV/AIDS drug Prezista for sale in Africa and other poor countries. The US healthcare group said it would not enforce patents, provided generic firms made high-quality versions of the drug - known generically as darunavir - for sub-Saharan Africa and Least Developed Countries. Prezista used when patients develop resistance to older antiretrovirals. J&J has an existing deal with Aspen, which makes Prezista at a discounted price for Africa.

6. FINANCIAL NEWS

6.1. Financial News: Companies

Aspen Pharmacare: In April, Aspen acquired some of GlaxoSmith Klein's (GSK) over-the-counter brands for R2,1-bn in territories excluding Europe and North America. In May Aspen was the JSE's best-performing blue-chip stock for the previous six months, rising by more than 36% to R120,40. The company announced its black economic empowerment (BEE) partner, Imithi Investments, would sell Aspen shares as part of the

BEE transaction concluded back in 2005. In September Aspen announced that it will focus on its Latin American and Asia Pacific businesses after reporting a 23% increase in revenue to R15,3-bn. from continuing operations. Operating profit was up 25% to R3,9-bn. Aspen won (20,6%) of Government's HIV triple pill tender.

Cipla Medpro: Indian pharmaceutical company Cipla made a bid for a 51% stake in SA's Cipla Medpro at R8,55 a share. Jerome Smith, CEO and founder of Cipla, who has resigned after Cipla Medpro's board suspended him and charged him with a string of alleged financial irregularities, dismissed speculation that he might return to the company should Cipla India's bid succeed. With 4,465-m shares in issue, the proposed deal would be worth about R1,95-bn. But analysts argued that Cipla Medpro was worth more than that. Cipla won almost 25% of the tender for the HIV triple pill that state patients will start receiving in April 2013.

Adcock Ingram with an estimated staff of 2 000 people in SA, offered a retrenchment package to workers who wished to volunteer. Adcock has had a tough trading period since the withdrawal by the MCC last year of painkillers containing dextropropoxyphene and the loss of an ARV tender worth more than R660-m over two years. In July Adcock acquired the brands of Indian pharmaceutical company Cosme Farma Laboratories for R708-m. Adcock reported a 19% drop in operating profit to R869-m for the year to September 30, as consumers opted for cheaper products and the cost of imported ingredients rose due of the weak rand. Adcock faced steeper input costs thanks to higher water, electricity, transport and labour bills. The company reported a 2,4% increase in revenue to R4,64-bn, while headline earnings per share fell 9% to 422,4c, and earnings before interest, tax, depreciation and amortisation (ebitda) dropped 16% to R986-m.Turnover in its prescription business decreased by 6,9%; over-the-counter turnover rose 11,4% to R1,79-bn.

GlaxoSmithKline (GSK): In July it was reported that GSK agreed to plead guilty and pay $3-bn to settle the largest case of healthcare fraud in US history. The settlement includes $1-bn in criminal fines and $2-bn in civil fines in connection with the sale of the drug company's Paxil, Wellbutrin and Avandia products. In November GSK announced plans to buy about 321-m shares of GSK Consumer Nigeria for a total of $100-m. GSK also offered to buy 13,4-m shares of India's GSK Consumer Healthcare for $940-m. The offer price in both cases is about 28% above the previous last close for the shares. If it buys the maximum amount of shares in the offers, the company's stake in the India unit will rise to 75% and its holding of the Nigeria operation will climb to 80%.

Life Healthcare: In June it was reported that Life had beaten expectations on its listing in 2010, outpacing rivals Netcare and Mediclinic - largely because it is less encumbered offshore. Life purchased a minority stake in nine hospitals in India for some R800-m, opting not to expand into First World situations, where the South Africans' ability to add value is limited. Life's operating profit rose 17% to R2,54-bn, up from R2,17-bn in the previous financial year. A final dividend of 60c, up slightly on last year's 54c was announced.

Litha Healthcare: In September it was reported that Litha acquired Pharmaplan for R590-m. Litha's pharma division grew its turnover by 61% in the half-year to June. Earlier this 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. Litha’s priority is expanding into Botswana, Mozambique, Namibia, Swaziland and Zambia as it is already selling vaccines and consumable medical products to these markets. Litha reported its first set of quarterly results in November, following its acquisition by Canadian firm Paladin earlier this year, disclosing a disappointing three-month period. A transport strike, the weakening rand and lower than expected sales of pneumococcal vaccines affected performance.

Netcare: reported a R9,3-bn loss for the year to September as it wrote down the value of its UK business by R10,7-bn and saw a decline in its most profitable patients. Netcare owns a stake in the UK's biggest private hospital group, General Healthcare Group (GHG).

Mediclinic International: The hospital group refinanced its entire R28-bn debt facility, and said it aimed to raise R5-bn with a rights issue underwritten by Remgro and had renegotiated its R24,1-bn debt facilities to realise an annual saving of R550-m on financing costs. The refinancing arrangements include new Swiss debt funding of R17,85-bn; new SA debt of R4,2-bn; a local R5-bn rights offer; and a R2-bn issue of preference shares. Mediclinic's share price has risen by 25% since the beginning of this year. Mediclinic International announced the increase of its effective shareholding in Dubai's Emirates Healthcare to 100%. The company denied that the expansion was an indication of diminished prospects in SA, and anxiety about the introduction of NHI.

Medihelp: Medihelp ended its financial year with a surplus of R163,9-m and a solvency ratio of 29,2%. Medihelp has once again been awarded an AA- (minus) rating from the Global Credit Rating Company for its claims-paying ability.

Discovery: GlobalCredit Ratings has reaffirmed Discovery Health Medical Scheme's (DHMS) national currency claims paying ability rating at AA+ (ZAR), with a stable rating outlook. Discovery holds the highest rating that an open or closed medical scheme in SA can be accorded.

6.2. 'Fairer' Tax Treatment:

Proposed changes (Taxation Laws Amendment Bill) to the tax credits for medical expenses in the 2014⁄15 tax year will have an extremely negative impact on taxpayers over the age of 65 and on taxpayers with disabilities, according to the Association for Savings & Investment SA (Asisa). The amendments will remove current deductions for taxpayers over the age of 65 and introduce: a tax credit at a rate of 30% for medical scheme contributions up to a certain limit; and a tax credit at a rate of 33,3% for both medical scheme contributions that exceed certain limits and unrecouped healthcare expenses. Taxpayers who are disabled or have family members with disabilities will be entitled to a tax credit equal to 33,3% of their unrecouped medical expenses plus their contributions that exceed three times their initial tax credit. Asisa believes these people should be entitled to deduct all their medical expenses or the tax credit should be raised to 40%.

From the 2014⁄2015 tax year, taxpayers under the age of 65 will receive a tax credit at a rate of 25% for unrecouped medical expenses that exceed 7,5% of their taxable income.

Senior tax associate at law firm Cliffe Dekker Hofmeyr, Andrew Seaber, said National Treasury believed a tax credit system would facilitate the long-term goal of a NHI system where all taxpayers would make an equitable fiscal contribution to health insurance.

Associate director at KPMG, Johan Troskie, described the proposed changes as "a misguided sense of equity". In the first phase (1 March 2012 – 1 March 2014) taxpayers 65 and older will qualify for deductions on all contributions to medical schemes and out-of-pocket expenses.

7. GENERAL NEWS:

7.1. General News: South Africa

Eyecare: A groundbreaking international initiative by the International Centre for Eye-Care Education will provide eye-care education to more than 640-m people worldwide. It was introduced by Prof. Kevin Naidoo (University of KZN), and consists of core teaching and learning units of an optometry degree programme in a downloadable format that enabled educators and students globally to access course notes and presentations by top optometric educators worldwide.

New imaging unit gives sports medicine a boost: An advanced imaging machine was launched at Pretoria's high performance sports centre, earlier in the year. It is capable of seeing sports injuries in the highest resolution possible. The Philips 3.0 Tesla MRI unit installed is a first for the country.

Dialysis treatment offered at night: Since April this year people suffering from kidney failure may receive dialysis treatment at night. The overnight options are Greenacres, Port Elizabeth, Netcare Sunninghill Hospital in Johannesburg and at Netcare Umhlanga Hospital in KwaZulu-Natal. Another unit will open shortly at Netcare Garden City Hospital in Johannesburg.

Groundbreaking new hip, knee surgery: Tembisa Hospital has been chosen by medical technology company Smith & Nephew to launch a pilot project for knee and hip replacement surgery. The replacement device, Visionaire, is made exactly according to the patient's anatomy, using a 3D model. Dr Richard von Bormann, president of the SA Knee Society and a consultant orthopaedic surgeon at Groote Schuur Hospital, performed the surgery.

SA scientists generate stem cells from adults: The Council for Scientific and Industrial Research announced that SA scientists had generated "induced adult pluripotent stem cells" from adult skin cells and it can be prompted to grow into any type of adult cell, such as those in the heart or brain.

Three Health Sins: Liquor, Tobacco and Obesity

'Big Food' taking bite out of SA health:
A report from the Centre of Metabolic Medicine and Surgery (CMMS) stated 66% of women and 33% of men in SA were overweight and 10% of men and 28% of women might be morbidly obese.

According to US research (Prof I-Min Lee from Harvard), South Africans are among the most inactive people in the world - (58% of the women and 48% of the men are couch potatoes). This leads to people likely to suffer from chronic conditions such as diabetes, hypertension and cardiovascular diseases. Prof Lee said SA was in the third place for obesity in the world.

A study by the University of the Western Cape's School of Public Health found "Big Food" manufacturers had increased their share of the market by making their food more available, affordable, and acceptable and supermarket chains now control over half the retail share of the food market. Healthier foods cost 10% - 60% more in supermarkets than less healthy food.

SA's Food manufacturers have until June 2016 to comply with the first set of sodium targets, and another two years to meet the next. The draft regulations to the Foodstuffs, Cosmetics and Disinfectants Act will apply to local and imported food products.

Investment: According to Sarbjit Nahal, an equity strategist at Bank of America Merrill Lynch Global Research "global obesity is a mega-investment theme for the next 25 years and beyond". A report, called "*Globesity - The Global Fight against Obesity*", has identified more than 50 global stocks related to fighting obesity, focusing on pharmaceuticals and healthcare; food; weight loss; diet management and nutrition plans; and sports apparel and equipment. Obesity adds up to 50% to global medical costs.

The smoking issue: The Constitutional Court has turned down a legal challenge by British American Tobacco SA against a ban on smoking advertisements. The court declined to hear an appeal of a judgment upholding the ban by the Supreme Court of Appeal in June of this year.

Battle looms over shock move to ban liquor ads: 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 products; 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 sponsorships to brand names; and prohibit the promotion of alcohol 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.

7.2. General News: International

Test allows doctors to see disease: Scientists in Britain have used a super-sensitive test using nano-particles to scan for molecules of p24, a marker for HIV infection, and Prostate Specific Antigen or PSA, an early indicator of prostate cancer. The technology was 10 times more sensitive than existing standard methods and also 10 times cheaper.

Tackling genetic disorders: A US company is about to announce the "$1 000 genome" - a read-out of a person's complete genetic information for about the cost of a dental crown. The genome-sequencing machine from Ion Torrent in the USA is 1 000 times more powerful than existing technology. The tabletop machine will sell for $99 000 to $149 000, making it affordable for large medical practices or clinics. Existing sequencers cost up to $750 000. Some scientists and physicians, however, say this opens the door to widespread whole-genome sequencing, even of people who are not ill.