# SUMMARY OF HEALTH NEWS
# APRIL 2013

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**APRIL HIGHLIGHTS:**

***The Good News: Syrians say SA doctors worth their weight in gold***

On April 28 *The Times* reported: "South African medical professionals received a heroes' send-off as they left Darkoush, in north-west Syria after working12-hour shifts since arriving, treating patients in the hospital, at a second clinic in the town, and in mobile clinics. Driving out of town in a convoy of minibuses, the team was treated to a sea of smiles and friendly waves after helping the community for 10 days. Every member of the team received a small bottle of perfumed oil and a hand-written note, saying 'All the gold in the world is not enough to thank you'."

***Less Good News: Blackout on National Health Insurance plan (NHI) feared;*** *The Times, 5 April 2013*

* **One year after kicking off the R150-m NHI pilot sites in 11 of SA's 52 health districts, early assessments have highlighted dire shortcomings.**

* **An in-depth newsletter examining how the NHI would work, posted by the Council for Medical Schemes (CMS) has been removed from the medical aid regulator's website**. The council was pressured to remove it by an official at the Department of Health (DoH), said health economist Prof Alex van der Heever from Wits. **The articles, written by healthcare experts, expressed different viewpoints on how best to provide high-quality healthcare to all South Africans.** CMS spokesman, Dr Elsabie Conradie, blamed a computer problem for the link being dead.

* **A recent audit by National Health Facilities Audit team of public health facilities has for the first time provided the DoH with baseline information against which future progress can be measured.** The audit has delineated clearly the many failings of the public health services. Facilities fared worst on "positive and caring attitudes", with a countrywide average score of only 30% for compliance with vital measures in this area. The worst staff attitudes towards patients were found in the Northern Cape, where facilities scored a dismal 17%, North West (21%) and Eastern Cape (22%). The average score for patient safety was 34%, while the average cleanliness and infection control scores were both 50%.

* Asked about the success of implementing the 11 NHI pilot projects, Health Minister Aaron Motsoaledi said **Government "was trying something new and we don't know how it will work".**

## 1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

***A condensed summary of CMS publication on the NHI; Many clinics and hospitals falling short***

*The Times, 8 April; Health-e News Service, 29 April, 2013*

Bad hospital management, a lack of doctors, political appointments, long waiting times, endemic corruption and no accountability of leaders are the problems that experts say plague government healthcare and that will have to be dealt with if NHI is to be implemented. Government proposals for fixing the healthcare system do not address the systemic problems, experts say, but instead suggest spending more money.

**Health economist Alex van den Heever** said decision-making had been centralised and politicised, internalising inefficiencies and dramatically increasing corruption. He called for systemic changes to healthcare, adding that all that had been proposed thus far was to increase taxes.

**Strategic Health Reform Project manager Kate Francis** said "throwing money" at the problem would not help as SA spent more on healthcare than its peer countries and yet health outcomes were far worse.

**Spokesman for the Board of Healthcare Funders (BHF) Heidi Kruger** said SA spent 8,5% of its gross domestic product on healthcare with poor outcomes when compared with similar middle-income countries. **Not enough money and doctors:** The chief director for health and social development at the Treasury, Dr Mark Blecher, said though the government would spend about R122-bn on health in this financial year, SA would be R80-bn short if it were to implement the scheme in full. Dr Dumisani Bomela, from the Hospital Association of Southern Africa (HASA), said for improved health there was a need for "significantly increased numbers of doctors and nurses". **Current shortage: 48 000 nurses, 4 000 doctors, 7 000 specialists**. **Bomela called for a change to regulations to make it legal for private institutions to train doctors. He expressed hospitals' willingness to work with the government to roll out NHI and suggested private-public-partnerships where the state paid private hospitals to treat government patients.** In response to a call for doctors to be involved in NHI, the South African Medical Association's (SAMA) Dr Darian van Loggerenberg said doctors would only do so if they were paid in line with their experience. **He said the recent proposed guideline tariffs to regulate doctors' fees were 5% less than the association proposed in 2003, and the cost of living had increased by 55% since then.**

**Ground work done to prepare for scheme's roll-out:**

**In a paper titled *NHI, the first 18 months*, the DoH explained its plan to ensure that everyone had access to "appropriate, efficient and quality health services".**

**This is what has been achieved:**

* A thousand medical students were sent to Cuba in September to increase the number of doctors;

* About 102 new CEOs of hospitals have been appointed;

* A leadership and management academy for doctors and academics has been established.

* In February, 88 new CEOs received five days training at the academy;

* All 3 380 government hospitals and clinics were audited last year. The worst-performing 1 000 units have been meeting with "facility improvement teams" to improve the availability of medicines, patient safety, infection control, staff attitudes and reducing patient waiting time;

* A school health programme was launched in October to offer services to pupils via mobile clinics;

* A Health Standards Compliance Office was established to monitor hospital standards. Inspectors were recruited and 171 hospitals have been inspected this year. They will revisit the poorest-performing;

* Eleven NHI pilot districts nationally have received an extra R3-bn in funding over two years;

* About 600 GPs have been contracted to start working in the short-staffed 11 pilot districts;

* Treasury is researching how to create an NHI fund that will be a single fund to pay for private and public healthcare. A paper on the fund is expected to be released later this year; Options to raise the money include a payroll tax that employers pay per employee, or higher value-added tax.

* **Motsoaledi's list of non-negotiables:** better infection control; regular medicines and medical supplies; essential equipment and maintenance; adequate laboratory services with blood and vaccines; improved infrastructure; and, district health teams that take specialists to people in smaller town.

* **The newly formed Office of Health Standards Compliance in the DoH will be the custodian of these standards** and will send inspectors to monitor facilities.

* **Commitments made by the pilot districts included:** Thabo Mofutsanyana (Free State), Tshwane and Vhembe: R24-m for buying basic equipment such as charts for conducting eye tests, blood pressure-monitoring machines and scales; Tshwane: R960 000 for contracting 12 general practitioners for three months; Vhembe: R1,8-m for computers to strengthen the district health management team; Gert Sibande (Mpumalanga): R2,2-m to buy furniture and clinical equipment for school health teams, family health teams and district clinical specialist teams; and, Eden (Western Cape): R1-m for the school health programme. Government was targeting 600 doctors this year to work at between 400 and 500 clinics.

***NHI pioneers new payment system for doctors***

*Mail & Guardian, 26 April 2013*

About 350 private doctors will sign contracts to start working part-time in May at rural public health facilities in NHI pilot sites, according to the DoH director-general, Precious Matsoso. They will attend DoH workshops to familiarise them with NHI "quality control, payment and monitoring systems". She said the treasury had allocated R239-m to contract 250 doctors over the next financial year, but the department also had access to "development aid funds" that would enable it to contract about 600 doctors. The doctors will be reimbursed for travel costs, but will not be permitted to serve state patients from their own private practices.

***NHI and tax;***

*The Sunday Times, 21 April 2013*

The NHI plan could slap South Africans with an increase of 24% to 35% in personal taxes. Health economist Prof Alex van den Heever said the lack of any practical reforms meant changes were unlikely to happen soon, and public hospital performance would not improve as there were no meaningful strategies in place to address governance failures. It did not make sense for a developing country like SA to spend more on subsidising healthcare when the amount already allocated by the government was spent so inefficiently.

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

***Increase in lifestyle diseases; Fewer South Africans dying of HIV/AIDS, but more of diabetes;***
*The Sunday Independent, 14 April; Health-e News Service; 12 April; The Cape Times, 15 April 2013*
According to Statistics SA's latest report on mortality and causes of death in 2010 the death rate was 6,2% less than the previous year on 543 856 deaths. TB was the leading killer 12% of recorded deaths; HIV/AIDS was the leading cause in 18 325 deaths during 2010, but there might still be a measure of under-reporting HIV/AIDS as a cause of death due to stigma and amid extremely high co-infection between TB and HIV/AIDS. **The second highest causes of death were influenza and pneumonia** followed by intestinal infectious diseases, forms of heart disease and deaths due to cerebrovascular diseases, or blood vessel-related brain dysfunctions like strokes. Diabetes accounted for 21 475 deaths in 2010, up from 20 680 the previous year, and hypertensive diseases led to 14 890 deaths. Health economist Prof Alex van den Heever, said the report suggested "a turnaround" due to ARV treatment which meant more people lived longer.

Statistics showed by mid-2011 just short of 18-m South Africans received ARV treatment. The majority of the 543 856 recorded deaths in 2010 were among black South Africans (34 1395). Just over 36 820 white South Africans died, 25 610 coloreds and 7 437 Indians, while 132 586 deaths were recorded in "other, unknown or unspecified" population groups.

* Meanwhile researchers from the University of Stellenbosch have called on the DoH to work more closely with them on TB to bridge the gap between research policy and how the disease is handled in clinics and communities. This could ultimately bring down the high rate of TB.

* ***A copy of this Stats SA report*:http://www.statssa.gov.za/Publications/P03093/P030932010.pdf**

***HIV: Primary clinics the key to treatment; Awards for scientists for work on HIV/AIDS***
*Business Day, 23 April; Health-e News Service, 3 April 2013*
Three medical scientists whose work challenged former Pres Thabo Mbeki's dogma on HIV/AIDS received national orders on April 27: Prof Glenda Grey, who has conducted pioneering studies into the prevention of mother-to-child transmission of HIV; Prof Quaraisha Abdool Karim, who has worked on developing methods to protect women from HIV; and University of KwaZulu-Natal vice-chancellor Prof William Makgoba, who challenged Mbeki's quixotic views on HIV/AIDS in the international journal *Nature.*

* Prof Francois Venter of the Wits Reproductive Health and HIV Institute has raised his concern in the *SA Health Review* about the state of many public health facilities threatening the expansion of the ART programme, particularly frequent ARV shortages and poor service delivery. At Helen Joseph, for example, 30 000 patients received ART in 2012. Many of them could be treated at primary health clinics, as decentralised models had shown, Venter said. Five "sub-populations" are not getting adequate access to HIV treatment - teens, foreigners, men who have sex with men, sex workers and men.

***HIV drugs failure cost SA R1,6-bn: single-dose ARV; Why has Gauteng run out of ARVs?***
*The Sunday Times, 14 April; Business Day, 9 April; The Times, 9 April; Mail & Guardian, 9 April 2013*
Taxpayers had to fork out R1,6-bn more than expected under a state ARV tender because the companies contracted to supply the drugs failed to do so. **The main culprit is said to be Sonke Pharmaceuticals, a little-known firm that was awarded 21%, worth R900-m of the tender.** Aspen Pharmacare was the largest single supplier, scoring 40,6% of the work. Allegedly because of companies like Sonke, DoH ended up paying R5,9-bn.

Not only did Sonke fail to deliver its 30% share of the ARV Tenofovir, but its failure sparked a nationwide shortage of the drug - compromising the health of the 5,6-m living with the virus.

* Meanwhile the Treatment Action Campaign (TAC) says numerous reports were received of medicine being out of stock across Gauteng, specifically ARVs, epilepsy and blood pressure drugs. Provincial health department spokesperson Simon Zwane pointed a finger at the suppliers. However, Zolani Kunene from Adcock Ingram said the 2013/2014 ARV tender award conditions allowed for a three-month lead time to supply initial orders. All orders thereafter were subject to a six-week lead time, and the company was currently on course to meet requirements. Aspen Pharmacare, said it had not halted distribution either, and was unaware of the problem

* At the launch of the new fixed-dose combination ARV (Tenofovir, Emtricitabine and Efavirenz ) into one pill Health Minister Aaron Motsoaledi said it would assist a great deal in the management and treatment of HIV. The launch follows the cancellation of a contract that prevented the distribution of one of the world's cheapest three-in-one ARV pills in October last year. The AIDS drugs tender, which was initially valued at R8,9-bn, has now been trimmed to R5,9-bn. **This saving meant more patients could be treated with the same budget.** As HIV-positive patients would now take only one pill a day as opposed to two doses of three to four drugs, compliance in taking the treatment is expected to improve, preventing the risk of drug resistance and the need to migrate to more expensive treatment.

Three pharmaceutical firms were contracted to supply the fixed dose to the department for R89,38, R94,80 and R95,50 for the treatment of one person a month. Previously the DoH spent about R120 to R130/person/month.

***ARVs alone won't save HIV infected mothers***

*Mail & Guardian, 24 April 2013*

Although almost half of all maternal deaths in SA are caused by HIV-related complications, **there is no evidence yet that Government's ART has led to a lower chance of pregnant women infected with the virus dying during pregnancy, childbirth or within 42 days thereafter,** says gynaecologist Eddie Mhlanga, the erstwhile director of maternal health at the DoH and former head of obstetrics and gynaecology at the University of KwaZulu-Natal. According to him it could not yet be said how ART had contributed to saving SA women during pregnancy and childbirth because access to the drugs was still problematic.

***Sanac hopes for three-million on ARVs by 2015***

*SAPA, 21 April 2013*

The South African National AIDS Council aims to have three million people receiving ART by 2015. Currently, there are 1,9-m people on treatment. Another Sanac target for 2015 was the elimination of mother-to-child transmission of HIV, and a reduction in the number of AIDS-related maternal deaths. The rate of mother-to-child HIV transmission dropped from 8% to 2,7% between 2008 and 2012, and 99% of mothers and infants at risk of HIV transmission were currently receiving ART. Sanac aimed to reduce TB incidence and mortality caused by TB in people living with HIV by 50% in 2015.

***Lethal bacteria on the rise in SA***

*Sunday Times, 7 April 2013*

**SA is facing a silent epidemic in hospital wards of potentially lethal bacteria that are resistant to all known drugs.** The National Institute of Communicable Diseases' laboratory had confirmed 63 cases of totally-antibiotic-resistant superbugs collectively known as Carbapenem-resistant Enterobacteriaceae (CRE) since two years ago. A

private laboratory, Ampath, has detected 96 CRE cases since February 2011. **The bug has been found in private and public hospitals around the country**. Able to survive in the human stomach and on hospital surfaces, it turns treatable infections into life-threatening cases by transferring its own drug resistance. The bug has yet to be declared a notifiable disease. Other superbugs reported in the country include OXA, KPC, VIMand GES. Prof Mark Nicol, chairman of the SA Society for Clinical Microbiology, said the country lacked the surveillance needed to get an accurate picture of superbug infections. Many multidrug-resistant bacteria were now endemic to SA hospitals

***Global Fund: Invest now, or pay forever***

*Health-e News Service, 9 April 2013*

The Global Fund to Fight AIDS, Tuberculosis and Malaria announced a goal of raising US$15-bn to effectively support countries in fighting these infectious diseases in 2014-2016. Mark Dybul, executive director of the Global Fund, said there was a choice: invest now, or pay forever. He said innovations in science and implementation had resulted in an opportunity to completely control these diseases. Effective funding can turn high-transmission epidemics into low-level endemics, essentially making them manageable.

## 3. DOCTORS, NURSES, HOSPITALS & TRAINING

***Doctors quitting over cut in overtime pay***. ***No witch hunt against Gauteng doctors Wits wants answers***

*The Star, 19, 29 April; The Times, 24 April; SAPA: The Cape Argus, 25 April 2013*

Charlotte Maxeke Hospital in Johannesburg is facing a meltdown and could lose its accreditation as an academic hospital as **specialists threaten to resign en masse because overtime pay is being cut and private work stopped.** The consequences: a severe shortage of specialists, increasing waiting times for patients to be diagnosed and surgery at the hospital coming to a near standstill.

* According to Jack Bloom, the DA's Gauteng health spokesman, the decrease in overtime pay for many doctors has resulted in an effective monthly salary cut of R5 000 to R10 000. Specialists were no longer allowed to work in the private sector after completing 40 hours in a government hospital. This has outraged specialists, who say a significant portion of their income is from the supplementary work because Government "pays too little".

* Last year 9 doctors were charged with fraud, contravening overtime contracts and the overtime policy after an investigation by the department; 2 doctors were found guilty, and the investigation of 6 continued.

* **Meanwhile the Gauteng health department has denied it is conducting a witch hunt against doctors** with regard to overtime and outside work. Acting provincial department head Ndoda Biyela said overtime and outside work were neither conditions of service nor an entitlement, but were instruments to compensate for work done over and above the normal eight hours plus overtime hours of work.

* **Prof Ahmed Wadee, dean of the faculty of health sciences at Wits, said contrary to what had been portrayed in the media, there was only a small group of doctors who had brought forth their complaints.** The faculty was in negotiations with the hospitals' chief executive officers and chief operating officers. He said, however, that "we support these academics and are extremely concerned about the gap that could exist should they resign". The university's agreement with the department was that doctors would spend 30% of their time at the university and the remaining 70% would be for service at public hospitals.

* ***Read SA Health Review*** **onhttp://www.hst.org.za**

***Eastern Cape district comes last in health delivery***

*Health-e News, 3 April 2013*

The OR Tambo district in the Eastern Cape was ranked bottom of the 52 districts in an audit measuring the state of health. It has the worst rate of newborn deaths in the country - double the number of newborns died in the district than the national average – 20,8 babies per 1 000 births compared with 10,2 nationally.

Almost triple the number of children under five died in the district's facilities in comparison with the national average (11,4%), while it had the third-highest deaths of children under a year. The district also had the second-highest teen pregnancy rate in the country (girls under 18).

* Cape Town's district hospitals were the best used, maintaining high occupation rates.

## 4. MEDICAL AIDS

***Public to get a say on medical tariff guidelines***

*The Star, 15 April 2013*

**Public opinion on the formulation of tariff guidelines to be used by medical practitioners when charging their patients** will be sought during road shows when members of the HPCSA tariff board visit four provinces next month. Board members are scheduled to consult the public during one-day meetings to be held in Cape Town, Durban, East London and Midrand.

The HPCSA formulated a set of guidelines last year but was forced to withdraw them after an outcry from role players, who all accused the professional oversight body of denying them a say in what they could charge.

HPCSA spokeswoman Lize Nel said **the public would be notified, via adverts placed in local newspapers, of the exact dates, venues and times.** Consultative meetings would be held between late May and early June. All submissions would be compiled into a document that would be presented to stakeholders.

***Medical aid rebate has side effects***

*Prof Matthew Lester (Rhodes Business School): Sunday Times Money & Careers, 31 March 2013*

The rebate system is designed to ensure that taxpayers under 65 receive a tax rebate of 25% of medical expenses. Many will score over the current system.

However, the old limitation of medical expenditure deductions to expenses exceeding 7,5% of taxable income did not die with the old system. Taxpayers under 65 will have to suffer a heart attack or similar discomfort before the medical expenses not covered will be sufficient to obtain a medical tax rebate exceeding the standard monthly medical aid rebate. So, most taxpayers under 65 only receive a tax subsidy of R242 per month: less than 10% of

“Surely, with a bit of thought, the modern company could retain a company doctor for staff and their dependants? Then they could reduce the extent of medical aid cover to major disasters only.”

***Consumers underinsured***

*The Financial Mail, 5 April 2013*

SA has the highest exposure to life insurance of any country except Taiwan and South Korea with premiums totaling 12,5% of GDP. But when it comes to traumatic events such as disability, there is severe underinsurance. This is the conclusion of a new study by True South Actuaries & Consultants. True South's 2010 calculation of the insurance gap in SA indicated that if families hoped to maintain their lifestyle after the death of the breadwinner, there needed to be a R7,25 trillion increase in life cover. There was also a need for a further R11,13 trillion in disability cover. Only 38% of the required permanent disability cover was in place. With pressure on pension funds and employers to hold down risk cover costs, it would be up to individuals to top up cover on the retail market.

***Metropolitan to open Cape clinic***

*SAPA, 22 April; Business Day, 5 April 2013*

Metropolitan Health and the Alpha Pharm National Health Network have teamed up to put affordable preventative and primary healthcare within the reach of more South Africans. Metropolitan is the first medical scheme administrator to invest directly in primary healthcare.

## 5. PHARMACEUTICALS

***Novartis court ruling setback for foreign firms in India; Ruling exposes two hazards for Novartis***

*SAPA-AFP, 1 April; Business Report, 3 April 2013*

India’s Supreme Court has rejected a plea from Novartis, the Swiss pharmaceuticals group, to patent its cancer drug Glivec. India's 2005 patent law recognises patents on innovative drugs, but sets a higher than usual threshold for granting them, especially for updated versions of existing drugs. Novartis provided most of the medicine used in the country through a donation programme. But in a previous hearing, India's Supreme Court judges said the programme was "a complicated scheme" and suggested that Novartis reduce the prices. India's generics drug industry is valued at about $26-bn.

* **The dismissal of Novartis's appeal makes room for India to produce the drug at a fraction of Novartis's cost** and allows the possibility of India exporting the cheap generic version to other markets. The drug, patented in more than 40 countries, costs R862,50 for each 400mg tablet in SA’s private sector. However, the generic equivalent is sold by Cipla for just R86 in India because there is no patent protection.

* Last year, an Indian court gave an Indian manufacturer the go-ahead to produce a generic version of a cancer drug made by Bayer. It cited the need to make medicines available to people at affordable costs.

* ***Editorial Comment: The Cape Times & The Star, 5 April:*** “The Indian Supreme Court’s decision is a victory for patients worldwide, especially the poor. It is important that SA takes note of this ruling as the Department of Trade and Industry drafts amendments to our outdated patent laws, which allows companies to easily register patents and extend monopolies, meaning the country is missing out on affordable life-saving medicines as frivolous patents block competition from generics. Amending the patent laws will still give drug companies an adequate slice of the pie - but, more importantly, it will free healthcare providers to focus on making sure the drugs reach the patients instead of having to find money to pay for treatment.”

***Pfizer's arthritis drug rejected by European regulators***

*Bloomberg, 25 April 2013*

Pfizer Inc's rheumatoid arthritis pill, Xeljanz, has failed to win the backing of European drug regulators, who said the drug did not show enough effectiveness in reducing the disease's activity in the body or slowing damage to joints, even though it improved symptoms. Xeljanz has already been approved in the US – it is said to inhibit part of the immune system that can cause rheumatoid arthritis. However, it may have side effects including tumors and infections.

***SA moves to secure cheaper medicines***

*Reuters, 22 April 2013*

**SA plans to overhaul its intellectual property laws to improve access to cheaper medicines by making it harder for pharmaceutical firms to register and roll-over patents for drugs.** Central to the reforms is closing a loophole known as "ever-greening", whereby drug companies slightly modify an existing drug whose patent is about to expire and then claim it is a new drug, thereby extending its patent protection and their profits. If approved by parliament, the changes should mean cheaper medication for cancer and HIV/AIDS in SA. Lobby groups such as Medécines sans Frontières (MSF) want SA to follow India's example and add a specific clause preventing companies from gaining patents on existing drugs, in a move that would help generic drug manufacturers.

## 6. FINANCIAL NEWS

***Bidvest's 60 % offer suggests backroom negotiations, Bidvest may see Adcock as defensive play***

*The Financial Mail, 5 April; Business Report, 5 April; Business Day, 2,3, 4, 8, 16 April; Citizen, 12 April*

*Tim Cohen: The Bottom Line: "*The takeover battle between Bidvest and Adcock Ingram is turning into a ding-dong affair, and like many tough takeover battles, it is exposing an interesting and important part of takeover law. If I am right, then the Adcock board is in a much tighter position than many suspected. This makes their 'go legal route' tactic a bit more explicable, since what they want to avoid, is to put any kind of bid to shareholders."

* **Suggestions that Swiss-based Baxter Healthcare had a call option to veto a change of control if Bidvest won the backing of Adcock's shareholders were scotched**. Research showed that Baxter Healthcare and Adcock had cancelled the option years ago. Supply agreements between Baxter Healthcare and Adcock would remain in place until 2023 and Bidvest could benefit from these agreements if it were successful in its bid. Bidvest is canvassing Adcock's diverse ownership. Bidvest CEO, Joffe said it would take the group a while to speak to Adcock's shareholders

* Adcock has iconic brands in its stable: Panado, Compral, Corenza C, Cepacol, Bioplus and Myprodol Adcock is one of the few pharmaceutical manufacturers to receive FDA accreditation in Africa under the Pepfar (US President's Emergency Plan for Aids Relief fund) approval process. Pepfar has committed $15-bn in order to increase the distribution of ARVs throughout Africa.

***Cancer drug, Tamiflu lift Roche Holding's quarter sales.***

*Reuters, 11 April 2013*

A spike in US demand for flu drug Tamiflu and strong sales of mainstay cancer medicines lifted first-quarter sales at Roche by a bigger than expected 5%. The world's largest maker of cancer drugs said quarterly sales rose to $12,44-bn. Demand for Tamiflu - a smaller seller than Roche's cancer blockbusters - accounted for half the rise in the pharma division, with sales surging 84% in the quarter following a severe flu season in the US. Roche also has high hopes for a novel chemotherapy-carrying "armed" antibody called Kadcyla.

***Nestlé, Pfizer deal 'good for parents', Aspen makes offer for baby formula units***

*Business Day, 3, 19 April 2013*

The conditions for the approval of the merger between Nestlé SA and Pfizer Nutrition was a good outcome for SA parents with children using infant nutrition products, the Competition Tribunal said when it gave its reasons for approving the merger. The buyer would be compelled to rebrand the Pfizer Nutrition products referred to as the S-26 and SMA range of products. According to the tribunal this remedy had averted a likely price increase or quality deterioration of the merging parties' infant nutrition products because the merger would have led to a "three-to-two" consolidation. The global transaction - worth R105,3-bn - has been investigated by regulators in 15 countries.

* **Aspen Pharmacare has offered Rl,9-bn to acquire Pfizer's baby formula business in Australia and Southern Africa from Nestlé.** Aspen announced that it has reached an agreement with Nestlé SA to acquire licences, assets and shares in its infant nutrition unit, which distributes a portfolio of products in Australia, SA, Botswana, Namibia, Lesotho, Swaziland and Zambia. The portfolio covers infants, toddlers and early childhood, with premium, speciality and standard ranges encompassing brands such as S26 Gold, S26 and SMA. The deal gives Aspen the exclusive right of use of the Nestlé (previously Pfizer) S26 and SMA product trademarks for a period of 10 years in Australia and Southern Africa. Aspen will have the right to co-brand the licensed products in the first 10 years and to gradually transition them to Aspen-branded products. For another 10 years, Nestlé will be precluded from producing the licensed products, effectively giving Aspen a 20-year period to establish equivalent Aspen-branded products.

***Cipla Medpro buyout offer divides shareholders: Indian drug makers pin hopes on Africa to lift sales***

*The Financial Mail, 5 April; The Business Times, 31 March; Bloomberg, 11 April 2013*

State tenders are becoming a major source of revenue for local drugs firm Cipla Medpro South Africa (CMSA). The group almost doubled its state business from R372-m to R693-m in the year to December and it expects this to rise to R1-bn in the current financial year. The company was awarded 24% of the R6-bn government tender to supply ARV drugs over the next two years, which means the state will account for a third of Cipla's sales. The group was also awarded the respiratory tender.

However, gross profit grew by only 11% due to operating costs and the weaker rand, and the operating margin was only 16,7% (2011: 20,2 percent).

* Aslam Dalvi, an equity analyst at Kagiso Asset Management, said CMSA had to focus more closely on managing its cost base while continuing to take advantage of growth opportunities in Africa and the over-the-counter, nutrition and animal care markets.

**The proposed R4,5-bn acquisition of the local company by Cipla India would strengthen its position.**

A shareholder meeting has been called for April 30 to consider the deal. Acting CEO, Johan Du Preez, said there has been no indication from shareholders that they would oppose the transaction. The board supports it. Dalvi said given a potentially weaker 2013, Cipla India would be paying a full price and investors were well advised to consider the offer.

* **However, CMSA's empowerment partner and largest shareholder, Sweet Sensation, indicated opposition to the "low-ball" offer of Cipla India to buy out all the CMSA shareholders at R10 a share.** The other shareholders want to see a secret 20-year supply agreement with Cipla India before voting.

* Meanwhile Cipla India forecasts products for cancer and respiratory ailments in Africa will help it boost sales fivefold by 2020. Chandru Chawla, the head of international business and corporate strategy said Cipla was seeking to partner with marketing firms in Kenya, Nigeria, Algeria and Morocco. Indian generic companies were well positioned to compete in Africa as their production costs were way lower than those based in Europe and SA.

* According to *The Business Times* (28 April) CMSA directors and key staff are in for a rich payday if shareholders approve the takeover. A circular to shareholders said R53,3-m will be paid to the company's employee share ownership scheme participants to accelerate their share options. **Four Cipla Medpro directors - Bongani Caga, Sbu Luthuli, Mark Daly and Nthabiseng Mokone - will get a combined R31,7-m for shares held directly and indirectly.**

***New drugs, acquisition boost J&J***

*Bloomberg, 16 April 2013*

First-quarter earnings of Johnson & Johnson (J&J) beat analyst estimates as new drugs and the acquisition of Synthes boosted sales of the world's biggest producer of healthcare products. Earnings excluding onetime items were $1,44 (R13) a share, topping by 5c the average of 11 analysts' estimates compiled by Bloomberg. Net income fell 11% to $3,5-bn from $3,91-bn a year earlier. J&J is focusing on increasing sales of newly approved medicines, including the prostate cancer drug Zytiga and stroke prevention treatment Xarelto to help overcome lost revenue from generic competition.

***Clicks captures more of pharmacy market***

*Business Report, 26 April 2013*

Health and beauty retailer **Clicks Group is gaining market share in the private pharmaceutical sector as a result of the contraction of small independent pharmacies**. The group's CEO, David Kneale, said Clicks was taking market share from independent pharmacies and across the board. The retailer opened 18 pharmacies in the first half of its financial year and will open 30 more in the full year to August. Clicks now has 430 stores, with 324 stores having in-store pharmacies.

## 7. GENERAL NEWS:

***In India, 'no frills' hospitals offer $800 heart surgery***

*SAPA-AFP, 21 April 2013*

The "no-frills" Narayana Hrudayalaya clinics in southern India use pre-fabricated buildings, strip out air-conditioning and even train visitors to help with post-operative care, and cut the cost of heart surgery to an astonishing $800. The clinics are famous for his "heart factory" in Bangalore, which does the highest number of cardiac operations in the world. The latest Narayana Hrudayalaya ("Temple of the Heart") projects are ultra low-cost facilities. The model is likely to burnish India's reputation as a centre for low-cost innovation in the developing world. From the present 6 000 beds in 17 clinics, the aim is to expand privately-run Narayana Hrudayalaya Hospitals to a group with 30 000 beds in the next five years.

***Cutting Research & Development costs 'not a sign of health'; Global bid to publish all clinical studies***

*Bloomberg, 23 April; Business Day, 29 April 2013*

**Biotechnology companies worldwide boosted profit by 37% to a record $5,2-bn (R48-bn) in 2012, partly by tempering growth in R&D spending**, according to Ernst & Young. The record profit did not necessarily tell an encouraging story about the industry, where R&D spending was the engine of future growth, according to Glen Giovannetti, Ernst & Young's global life sciences leader. He said while 2011's boost in investment seemed to signal a rebound from the economic downturn, the slower growth last year meant it was not completely over.

Meanwhile the Medical Research Council (MRC) has signed the global AllTrials campaign to get pharmaceutical **manufacturers and scientists to publish all their research on medicines, and not just the studies with favourable results**. The Cochrane Collaboration, a non-profit organisation which conducts systematic reviews of clinical trials, has been lobbying for years to get better access to research data, which is often withheld by pharmaceutical companies. Recently its work has exposed how Swiss drug maker Roche withheld clinical trial data on the antiviral drug Tamiflu, which was stockpiled by US and European governments in the expectation that the medicine would prevent deaths from swine flu. Roche is now facing tough questions over the efficacy of Tamiflu, which Dr Kredo described as "no better than Panado".

***HPCSA withdraws from conference to protest Karabus' UAE detention***

*SAPA, 17 April 2013*

The Health Professions Council of SA (HPCSA) has withdrawn from an international medical conference in protest against the detention in the UAE of local doctor Prof Cyril Karabus. The council had decided to boycott the conference and exhibition as it would not be associated with the travesty of justice as in this case. The Africa Health Exhibition, which is run by the Dubai-based company, Informa Life Exhibitions, is scheduled to be held next month in Johannesburg. Karabus, 78, has been held in the UAE since August on charges of manslaughter and falsifying documents after the death of a three-year-old Yemeni girl he treated for leukaemia in 2002.