

SUMMARY OF HEALTH NEWS: JULY 2013

IN THIS ISSUE:

INDEX

1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH: (p 2 - 3)
2. NEWS ON HIV/AIDS, TB, MALARIA & COMMUNICABLE DISEASES: (p 3 - 4)
3. DOCTORS, NURSES, HOSPITALS & TRAINING: (p 5 - 6)
4. MEDICAL SCHEMES: (p 7 - 8)
5. PHARMACEUTICALS: (p 8)
6. FINANCIAL NEWS: (p 9 - 10)
7. GENERAL NEWS: (p 10 - 11)
8. IN A NUTSHELL: (p 11 - 12)

JULY HIGHLIGHTS:

What Singapore can teach SA about healthcare

Business Day, 22 July 2013

US specialist and former Harvard professor, Dr William Haseltine recently visited SA to promote his book *Affordable Excellence, The Singapore Healthcare Story*. **Haseltine believes aspects of Singapore's public health system can be successfully implemented in SA.**

Singapore spends less than 4% of its GDP on health (SA spends 8.3%), yet it maintains a top-quality, universal healthcare system. Government pays tax-free 4% interest on savings in a Central Provident Fund (CPF) and fosters personal responsibility through the CPF's "3M" (Medisave, Medishield and Medifund) system. It provides coverage for daily health needs to catastrophic illnesses and acts as a safety net ensuring that even the poorest Singaporeans receive a level of care.

People are free to use either the public or private system, according to willingness and ability to pay. Public hospitals are obliged to provide care regardless of ability to pay; no proof of ability to pay is required before admission and there is high-quality maternal and child care throughout. Singapore also has a well-developed infrastructure, an inexpensive mass transit system, and supports healthy living through fresh food markets (wet markets), island-wide park connectors and exercise stations, and ministry-funded community centres in every neighbourhood.

The government is developing a master plan to broaden current public-private partnerships to enhance the treatment of chronic diseases and form a team approach to care.

1. NATIONAL HEALTH INSURANCE (NHI) & PUBLIC HEALTH

Underspending in NHI pilots raises doubts; NHI nowhere near ready for roll-out

Business Report, 25 July; Business Day, 26 July 2013

A year after the launch of the NHI pilot project in 11 health districts, **a third of the districts involved in the experiment have spent barely half their allocated budgets**, according to a government-commissioned review. A conditional grant of R150m was allocated for the fiscal year 2012-13, with some provinces adding extra funds intended to strengthen the health system, to test innovations necessary for implementing NHI, and to strengthen revenue collection at central hospitals. Only a third of the 556 primary healthcare facilities assessed in the pilot districts were ready to start contracting services from private sector general practitioners, health director-general Precious Matsoso said. The review documents show the districts that made the most progress were Eden, and Umzinyathi and Umgungundlovu in KwaZulu-Natal.

At the moment no district health authorities have been appointed under the NHI pilots and only 4 of the 10 districts have appointed NHI project managers. Only 3 districts had refurbished all their hospitals in the 12 months of the NHI piloting period.

- * **About 300 GPs in private practice have been contracted to work with the NHI projects, but only 125 can be placed** because so few of the facilities are ready to accommodate them.
- * The Actuarial Society of SA has estimated, based on present private sector spending patterns, that **NHI will cost as much as R336bn to implement**.
- * **Health economist Alex van den Heever said the pilot project was not testing the crucial aspects of universal healthcare coverage**. Regarding the funding model, he said government should open a public debate and this should not only be the Treasury's determination.
- * The long-awaited **white paper - the next policy step needed before drafting laws to bring the NHI into effect - has been in the pipeline for nearly two years**. Government's tardiness in releasing it would indicate that affordability is an obstacle that is not going to be easy to get around.

NHI Seeking a remedy

Financial Mail, 5 July 2013

Health Minister Aaron Motsoaledi has been lobbying support for NHI in SA and has encouraged everyone who can to help fix the ills in the health system. Last month, when addressing leaders of the SA Council of Churches, he dropped a bombshell by **claiming that private healthcare groups were preparing a high court case to stop the NHI**. He repeated this in an interview with the *Financial Mail*. This will undoubtedly cause a huge rift with government. It also indicates how high the stakes are when it comes to healthcare costs, since a cap on fees is likely under the NHI.

Motsoaledi has often blamed private healthcare for high healthcare costs - in particular the three dominant hospital groups, Mediclinic, Life Healthcare and Netcare, which together control 75% of the market.

- * He's backed by a report produced in 2009 by **Judge Jody Kollapen**, then chairman of the Human Rights Commission, who researched access to healthcare in the spirit of Section 27 of the Constitution.
- * He's also backed by **Humphrey Zokufa, MD of the Board of Healthcare Funders (BHF)**, representing 85% of medical schemes, who argues that the imbalance in the legislation puts medical schemes in a weaker position when negotiating with hospitals.
- * **Prof Alex van den Heever blames consumers of being price insensitive**, since they expect insurance or medical aid to pay when they're sick. Another problem, he says, is market concentration of the providers.
- * **Discovery Health CEO Jonathan Broomberg** says healthcare costs rise faster than CPI in most countries and surveys show that healthcare inflation in SA runs at 3% above CPI. "More services are being consumed by medical scheme members each year, and this is driven by both demand- and supply-side factors. On the demand side: ageing, chronic diseases like diabetes, cholesterol, HIV/AIDS and cancer; on the supply side: the

shortage of doctors, particularly specialists.

- * **Specialists**, however, put it differently. "Conditions that need specialists have high costs," says **Adam Nosworthy, a medical oncologist** at Donald Gordon Medical Centre. "The pharmaceutical industry is hiking its prices significantly and that's becoming a barrier to care in both the private and public sectors."
Chris Archer, an obstetrician and CEO of the SA Private Practitioners' Forum, agrees that the absence of **tariff regulation is a problem because doctors don't know what's appropriate.**
- * **The system is also wasteful.** Doctors commission numerous tests on patients but do not necessarily share the results with their colleagues when referring patients. Just as there is **no consensus on what drives costs, there is no consensus on what needs to be done.** Suggestions range from the moderate to the radical. **One of Motsoaledi's proposals is a health commission** - a statutory body - to regulate prices. But this would only be possible once it's clear how prices are determined in the private sector.

Broomberg suggests a 'capitation' system, in which a health professional or group is paid a fixed fee per person per year, to look after a defined registered population.

Hospital groups want to be allowed to employ doctors who could be paid a fixed amount instead of a fee-for-service. Government is reluctant to permit that, ostensibly for fear it may not compete on salaries.

Doctors equally reject the idea. Archer says it would be "dreadful" and would create perverse incentives. "Doctors would be completely beholden to hospitals and would be told, as employees, to keep beds full."

- * **Another consideration is 'anti-selection' against medical schemes.** The Medical Schemes Act requires that schemes accept all applicants and charge the same premium, regardless of age or health risk. Says Broomberg: "The system creates an incentive for people to lapse their health cover when they don't need it, (young adulthood), and then join again later (when planning a family). This pattern robs schemes of young adults who contribute more than they claim, putting pressure on schemes and causing premiums to increase."

Sven Byl, head of healthcare & life sciences at KPMG says SA has only two of the three main pillars for healthcare: open enrolment and community rating - no mandatory cover. The NHI is a step in that direction. But it will be years before it's fully implemented. It would require a new architecture for our healthcare system, including a move away from a hospital-centered system and focus on primary and preventative care.

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

Draft policy looks at effects of AIDS, TB

The Star, 30 July 2013

Chronic fatigue, erratic school attendance, and learning difficulties as a result of ill health are some of the issues schoolchildren affected by HIV/AIDS and TB have to grapple with, according to the Department of Basic Education's draft policy on HIV/AIDS, sexually transmitted infections and TB. Infection rates among girls spike as they move from adolescence into young adulthood, though data suggests that there is a decline. Orphans and children in AIDS-sick homes experience more depression, post-traumatic stress symptoms, conduct problems, poor peer attachments, and somatic complaints than non-orphans. The document says the educational impacts identified among these children include missing and dropping out of school, hunger at school due to household poverty, and difficulty concentrating. In SA, where the HIV infection rate may still not have peaked, the number of orphans may well continue to rise until 2020.

The draft policy says school infrastructure and human resources are keys to managing and providing care and support for pupils and staff affected by HIV and TB.

New guidelines for HIV treatment; SA's maternal healthcare fails; WHO's guidelines may 'distract'

Health-e News Service, 25 July; Cape Argus, 3, 8 July 2013

The World Health Organisation (WHO) has recommended that HIV patients start getting anti-retrovirals when their

CD4 immune cell count was 500, up from 350. The CD4-count is used to determine the stage of the disease. WHO has also recommended that treatment should be given to all infected pregnant women and children under five, as well as other vulnerable groups, regardless of their CD4-count.

- * However, Prof Francois Venter, deputy director of Wits' Reproductive Health and HIV Institute, said the guidelines presuppose a strong healthcare system, but SA had seen drug stock-outs and some ARVs in short supply being substituted with others. He is also concerned of the build-up of toxicity in patients who are put onto the early HIV medicines, such as stavudine, for a longer period. The health benefits of treating everyone from CD4 of 500 were based on poor data, and HIV transmission was from people with CD4 counts of under 350 (about 85% of mother-to-child transmission of HIV was when the mother's CD4 count was below 350).
- * According to Anja Smith's research on Socio-Economic Policy (ReSEP) at Stellenbosch University, **SA is an upper-middle-income country that is achieving low-income country success when it comes to maternal health.** WHO statistics show that SA is among 40 of the worst maternal-health countries in the world, along with countries such as Ethiopia, Haiti, Liberia and Niger. Maternal mortality in SA almost doubled between 1990 and 2008. However, data on births in hospitals indicates that the turning point may have been reached in 2010. This improvement follows the implementation of the policy on the provision of treatment to all HIV-positive pregnant women with a CD4-count of 350 or lower, in 2009/10.

Drug row sparked by HIV spending; Tribunal to assess penalty for collusion on HIV tests

SAPA, 9 July; Mail & Guardian, 12 July; Business Day, 16 July 2013

A clinical trial that aims to see whether low-dose stavudine, or d4T, is as effective as tenofovir, or TDF, one of the ARVs currently recommended for first-line HIV treatment by the WHO, has sparked a heated debate. The study is to be conducted in SA, Uganda and India. Researchers want to see whether reducing the d4T dose from 30mg to 20mg will reduce side effects and still successfully suppress HIV, which would lower treatment costs. Globally, 26m people need ARVs. Doctors and activists say advocating that a bad drug should continue to be used by the world's poorer patients is unethical.

- * Two medical firms, Shekinah Medical & Disposables and Hosanna Medical & Disposables, involved in collusive tendering in terms of the supply and distribution of HIV rapid-test kits, has reached a settlement with the Competition Commission (CC). Hosanna settled on an administrative penalty of R37 597, or 5% of its turnover and Shekinah on an administrative penalty of R143 143, or 4% percent of its turnover.

New TB battlefront; Fungal diseases second to TB as a cause of death; National study; Faster TB test

Cape Argus, 1, 26 July; The Times, 1, 2 July 2013

The incidence of multidrug-resistant TB in SA is much higher than doctors thought, a new test has shown. The GeneXpert machine that gives TB results within hours, show that **5% of the 500 000 new TB cases diagnosed each year is drug-resistant, as opposed to the 1.8% that was previously thought.** Nazir Ismail from the National Institute of Communicable Diseases' Centre for Tuberculosis says multidrug-resistant TB takes two years of medication to cure and has about a 50% to 60% cure rate. Researchers have begun testing samples from 160 000 people, collected at 400 medical centres, for TB and drug-resistant TB.

- * A UCT study of 400 children from Khayelitsha showed that the new molecular test (GeneXpert) is the first to show success in testing children at clinics.
- * Many of the antibiotics to treat TB have toxic side effects, with one drug causing deafness. A recent article in the *PLOS journal* estimated treatment cost at R67 000 per patient. Both HIV and diabetes are risk factors for TB as they weaken the immune system
- * **Fungal infections are the second most (TB is the most common) common cause of death among HIV-positive people.** From 7 000 cases of cryptococcal meningitis cases diagnosed by the National Institute of Communicable Diseases (NICD), about 99% are attributed to people who are HIV-positive. Prof Graeme Meintjies, infectious disease specialist at UCT, says "they remain understudied and undiagnosed compared with other infectious diseases".

3. DOCTORS, NURSES, HOSPITALS & TRAINING

Sleepy doctors; Lack of funding for interns; Western Cape 'finds jobs for 98% of its bursary doctors'

Business Day, 2 July; Cape Argus, 5, 8 July; The Star, 4 July 2013

Trainee doctors don't get paid for overtime exceeding 80 hours, and **their overtime (up to 200 hours) is given "involuntarily under threat of not qualifying to practise medicine in SA,"** according to Nicolette Erasmus, reading for a PhD in corporate law at Wits. In an article in the *SA Medical Journal (Vol.102, No 8, August 2012)*, Erasmus says sleep deprivation amounts to cruel and degrading treatment and is contrary to international law. **"No other professional group in the country is subjected to such levels of exploitation and discrimination by the state."**

A request to the HSRC to investigate the situation was turned down.

- * In disregard for statutory limits on working hours, **state nurses are selling their off-duty time back to state hospitals** with the full knowledge of the state.
- * The National Education Health and Allied Workers' Union (Nehawu) called for an investigation into reports that the **DoH had not absorbed doctors into the public health system**. Spokesman Sizwe Pamla said several qualified medical interns, including community service doctors, were unable to complete their training because there was no funding for vacant posts. Dr Kgopotso Pege confirmed receiving complaints from 9 graduates from the University of KZN and Medunsa who could not secure places for their internship.
- * Meanwhile Faiza Steyn, spokeswoman for the Western Cape's DoH, says the province's public healthcare system absorbed about 98% doctors to whom it gave bursaries each year. The remaining 2% opted to work in the private sector. DA MEC for health, Theuns Botha, said the vacancy rate for doctors in the province was only 4%, compared with an average of 20% in other provinces.
- * Health Minister Motsoaledi commented in parliament on staff in the public health sector: KwaZulu-Natal has almost 33 000 nurses; Gauteng just over 24 000; the Eastern Cape 18 641; Limpopo 18 485; and Western Cape 11 447. Gauteng had the most doctors, 4 808; followed by KwaZulu-Natal with 4 040; Western Cape 2 746; Limpopo 1 159; and Northern Cape 405. The Eastern Cape had the most clinical associates, 53, followed by Gauteng with 30, and KwaZulu-Natal with 19. The Western Cape had none.

Crisis in SA nursing

The Times, 29 July 2013

According to a study by Prof Laetitia Rispel of Wits, **a third of 3 700 nurses surveyed had worked an extra job in the same year and 60% worked high levels of overtime at their regular job**. Just under half of nurses said that, at times, "they felt too tired to work while on duty". Nurses and managers told researchers that, unsurprisingly, tired nurses were more prone to make mistakes, which in turn impacted on patient care. Nurses in the private sector were more likely to moonlight, with 42% admitting to doing extra work, compared with 27% in the public sector. Almost 60% of specialised nurses trained to work in intensive care moonlighted, as there is a high demand for their skills. Most staff said they did it for financial reasons.

SA doctors graduate after Cuba training; Medical students 'not ready' for SA

Cape Argus 11 July; Cape Times, 11 July 2013

A group of **62 SA medical graduates who studied in Cuba as part of the SA-Cuba medical collaboration received their medical degrees at the University of Pretoria**. The group is part of a contingent of 1 344 students studying medicine at the University of Villa Clara in Cuba.

- * However, **medical experts have criticised the SA-Cuban doctor programme, saying the SA doctors were not adequately equipped when they came home**. Elma de Vries, a doctor based in Mitchells Plain and a former chairman of The Rural Doctors' Association of Southern Africa, said the freshly-trained doctors **have not been trained to deal with TB, HIV or the complications of diabetes and women in labour**. Errol Holland, chairman of the SA Committee of Medical Deans, said Cuba had a preventative healthcare system and SA was not there yet.

Gauteng: A dose of hope for horror hospitals; Hospital still not healed; Gauteng in dire health
City Press, 14, 28 July; Financial Mail, 5 July; The Times, 26 July 2013

Gauteng health department has come up with an operational plan, with the help of the province's three medical universities, to guarantee its major hospitals have the equipment, drugs and medical supplies they need. **The plan will be rolled out in 20 of Gauteng's training, regional and specialist hospitals.** Hospital CEOs are allowed to authorise the buying of equipment up to R500 000. Various committees will be set up to monitor availability of drugs; monitor whether essential equipment is available and functioning properly; and, a clinical committee, where heads of department will discuss the basic things that need to happen in order for their hospitals to function properly.

- * Health Minister Aaron Motsoaledi, the Gauteng health department and Wits signed an agreement that gives doctors and Wits professors the right to place orders for medicines directly with suppliers. Motsoaledi criticised the current depot system, saying medicine moved from supplier to multiple depots before eventually reaching a hospital.
- * **Reaction:** In *City Press* (28 July 2013), Kirsten Whitworth, attorney for the basic services at the Centre for Applied Legal Studies reacts to the new operational plan: "It is detailed, encouraging and certainly a watershed moment - **the closest the department has come to resolving the crisis in Gauteng's public health system.** The problems are severe, long-standing and systemic. It involves shortages of medication, staff, and fixed and consumable biomedical equipment; under-resourced emergency services; failure to maintain infrastructure; lack of food for patients; and limited or non-existent laboratory services. There is enough money. The department returned money to state coffers last year. **It has to be a sustainable and systemic change so that the problems do not simply reappear in a year's time.**"
- * **The Fostateng private ward system (11 years old) in four public hospitals - Charlotte Maxeke, Helen Joseph, Sebokeng and Pretoria West seems to have failed.** Fostateng was supposed to help retain professional staff in the public sector and speed up infrastructure upgrades and modern technology. Last year, losses amounted to R40m. At Helen Joseph, occupancy was 18%, at Sebokeng 20%; at Pretoria West 35% and at Charlotte Maxeke 76%.
- * DA's health spokesman, Jack Bloom says the department doesn't have the expertise to run private hospitals.

KZN health MEC 'has to go'

SAPA, 27 July 2013

The Health and Other Service Personnel Trade Union (Hospersa) has called for KwaZulu-Natal's Health MEC, Dr Sibongile Zungu, to quit or to be sacked over an apparent shortage of oxygen for the province's ambulances. The Emergency Medical Rescue Service (EMRS) had not received deliveries of oxygen cylinders for its ambulances for the past two weeks.

Compensation Fund moves to clear hospital payment backlog

Business Day, 25 July 2013

The Compensation Fund has paid R326m to private hospitals since January as part of clearing the backlog of late payments. Commissioner Shadrack Mkhonto said in a parliament briefing an additional R6,8m had been paid to public hospitals. This followed threats to withdraw services to Compensation Fund patients until the outstanding debts were settled. The fund, financed by a levy paid by employers and which deals with about 850 000 compensation claims each year, had **an accumulated surplus of R14bn at the end of March 2012.** In December, 123 520 invoices with an estimated value of about R300m were unpaid.

4. MEDICAL AIDS

New price list for doctors soon

Fin24.com, 5 July 2013

Shivani Ramjee, health actuary and head of actuarial science at UCT, has been appointed by the Health Professions Council to help compile guidelines "scientifically" for a new price list. The Health Professions Act makes provision for the council to set up price guidelines and deal with complaints of excessive pricing. **A new price list could be ready by January 2014.**

- * Because there was no reference price list, the council couldn't compare prices to see if they were excessive. This had resulted in patients being charged exorbitant prices without proper protection, the Competition Commission (CC) said in its submission. Medical funds are mostly using the 2006 price list (which has not been waived) and have adjusted it for inflation to determine what percentage of the price they will pay, or they negotiated individually with doctors.

Discovery joint venture takes Vitality to Asia; Discovery recovers R250m in fraud

Business Day, 18 July; Fin24.com, 30 June 2013

Discovery announced a joint venture with the Chinese AIA Group to establish the Vitality programme in the Asia-Pacific region. AIA is a leader in China's life assurance market, and operates in many other Asian markets. AIA Vitality was launched in Singapore and will combine AIA's brand, distribution and life insurance products with Discovery's proprietary wellness-based expertise and experience.

- * **Discovery Holdings recovered R250m in fraudulent claims last year** through a new accelerated analytics landscape built by Discovery Health in partnership with BITanium, an IBM business partner.

Medihelp: Small medical scheme hit as members cut expenses

Business Times, 30 June 2013

Medihelp last year recorded an R80,9m deficit - essentially a loss - far worse than the R47,3m deficit it budgeted for. The scheme also lost 17 000 state pensioners to the Government Employees' Medical Scheme (GEMS). But CEO Anton Rijnen said the scheme gained 15 000 new members and had 216 215 beneficiaries at the end of 2012. He said the R33m shortfall was "small change", considering the scheme paid out R3bn in 2012. Staff members have been told that they will not receive bonuses this year.

Sizwe's AGM disruption may delay recovery; Civil strife continues

Financial Mail, 12 July; Business Report, 2, 18 July 2013

Sizwe Medical Fund and its longstanding administrator, Sechaba Medical Solutions, are headed for a High Court battle after the curator of the scheme, Khaya Gobinca, cancelled the administrator's five-year contract, saying it had been awarded without going to tender. It was due to expire in 2016. Sizwe is Sechaba's only client. **The loss of the Sizwe contract (150 000 beneficiaries) could mean the demise of Sechaba.**

- * Earlier Gobinca warned that the disruption of the annual general meeting (AGM) could affect the period for which it was placed under curatorship. Gobinca walked out of the AGM.
- * Meanwhile the CMS has cleared Gobinca of blame for the implementation of contribution increases that contravened the scheme's rules. The CMS found that members' contribution increases for 2013, which averaged 10.82%, were in contravention of the scheme's rules as they were not approved by members.

Medical Schemes and gap cover: Filling the holes

Financial Mail, 19 July 2013

While government stalls in closing gaps in medical aid benefits, consumers are under pressure from having to take out additional cover. **For many, gap cover has become a necessity as medical aid claims are seldom paid in full.** Shortfalls have been as high as R100 000 for hospitalisation in recent years. The result has been **a steady growth in the gap cover industry, claiming to cover about 400 000 members.** The absence of tariff regulation or capping,

created the necessity for gap cover; meaning providers can charge more than medical scheme rates. Many families would have to sell their houses to pay the bill.

- * **To deal with this, schemes tend to shift the risk to members by creating gaps in the options they give, or charging for certain procedures against members' medical savings accounts or requesting them to use designated service providers (DSPs).** The CMS, working with National Treasury, the DoH and the Financial Services Board, are looking for ways to close the gaps and possibly abolish hospital cash plans. Draft regulations aimed at demarcating between short-term health insurance products and medical aids released were criticised by insurers and lawyers forcing the Treasury to release a revised version. It has yet to do so.

Wider life assurance options for people who have HIV

Personal Finance, 27 July 2013

Sanlam has announced that it will be one of the first large assurers to offer 'normal' life assurance cover of up to R5m to HIV-positive people. **People with HIV who take out Sanlam's 'normal' policy will have their premiums loaded, as is the case for anyone who has a chronic illness** when they take out life cover. The loading is applied on a sliding scale, depending on the stage of the disease, whether or not the policyholder is managing the disease well, and/or has any complications. Until now AltRisk has been the only assurer to offer standard life cover, albeit with a loading, to people with HIV. AllLife offers life and disability cover to people with HIV, but they are required to manage their health with AllLife's assistance.

5. PHARMACEUTICALS

Medical schemes 'getting to grips with drug budgets'

Business Day, 10 July 2013

A review by medical benefit management company Mediscor found that **overall medicine expenditure of medical schemes declined last year.** Mediscor's Madelein Bester said overall medicine expenditure declined for the second year in a row, dropping 0.6%; the average cost per item rose 0.2 %. It fell 5.1% between 2010 and 2011. This indicated that medical schemes were getting a grip on cost management, but it was also partly due to very low Single Exit Price (SEP) increases (2.14% in 2012). Generic utilisation rate increased to 53.4% last year, up from 52.4% in 2011 and 50% in 2010. The top five cost-drivers were Lantus SoloSTAR, an insulin product; the cancer drug Gleevec; Nexiam, which is used for treating stomach acid; breast cancer treatment Herceptin; and the painkiller Celebrex.

Big demand for 'legit' diet drug

The Times, 11 July 2013

Thousands of South Africans are trying to buy the new US prescription weight-loss drug Belviq online. Belviq is the first weight-loss drug to be approved by the US Food and Drug Administration (FDA) in 13 years. The FDA warned that the drug should be prescribed only to obese patients and must be used in conjunction with a reduced-calorie diet and exercise.

- * A survey conducted by the SA Medical Research Council concluded that 61% of the SA population was overweight, obese or morbidly obese. SA is third after the US and the UK in the world's obesity rankings.

Retailers set to supply public health medicines

Health-e News, 29 July 2013

Public health patients may soon be able to collect their medicine from private pharmacies in a massive public-private partnership that could eliminate medicine stock-outs. Possible retailers include Pick n Pay, Checkers, Clicks and Dis-Chem.

6. FINANCIAL NEWS

Chilean firm makes play for Adcock; CFR on negative ratings watch; JSE listing; Pressure on CFR Business Report, 5, 18, 23 July; Business Day, 4, 9, 17 July; Business Times, 7, 21 July 2013

Adcock Ingram announced that it had received a non-binding bid from CFR Pharmaceuticals to acquire all of its share capital at R73.51 a share. CFR is a generic drug maker and has been listed on the Santiago Stock Exchange since 2011. The Chilean company has a presence in Latin America, Southeast Asia, North America and Europe. If the deal were to go ahead, the combined firms would have revenue of about \$1,3bn and an asset base of about \$2,1bn.

- * **Fitch Ratings has placed CFR on a negative rating watch following its offer.** Adcock shareholders have responded with little enthusiasm to the offer, especially since part of the payment would be in shares of a company that was unknown to them and critical aspects of the offer were unknown. The offer followed CFR's \$562m acquisition last year of Lafrancol, a leading Colombian pharmaceutical company. 73% of CFR is retained by the founding family. The proposed transaction would see SA becoming CFR's most important single market. (41% of revenue vs. Colombia: 18%, Chile: 12%, Peru: 8% and Argentina: 7%).
- * Alejandro Weinstein, third generation to run CFR, said **CFR would shift the manufacturing of 300 to 400 products to SA, which would create jobs.**
- * **CFR would seek a secondary listing on the JSE.**
- * **The Public Investment Corporation (PIC), Adcock's biggest shareholder, said it would prefer that a SA company bought the company.** Bidvest also did not fit the PIC's bill for a new owner as it had no pharmaceutical interests.
- * **There seems to be growing pressure on CFR to alter its offer.** PIC said it would be willing to consider a strategic partner or investor if a cash offer was for a 50%-plus-1 control of Adcock while the balance of the company remained in local hands, including an appropriate black economic empowerment shareholding. This is not unlike what was put forward by Bidvest but at a significantly lower price of R62.
- * Oasis Group Holdings, one of SA's biggest fund managers, said the deal would imply shareholders giving up their stock relatively cheaply to invest in an unknown high-risk firm.
- * Meanwhile, **CFR shareholders approved a proposal to raise of about \$750m (R7,3bn) in additional equity** to help fund the proposed \$1,3bn acquisition of Adcock.

Beijing GSK officials confess to bribery; China and medical corruption; Aspen offers GSK £700m

Bloomberg, 17, 22 July; AFP, 1 July; Reuters, 11 July, Business Report, 25 July; Business day, 24 July 2013

China Food and Drug Administration said it would "severely crack down" on fake medications, forged documents and bribery. Eli Lilly agreed in December to pay \$29,4m to settle US Securities and Exchange Commission allegations that employees gave cash and gifts to officials in China, Brazil, Russia and Poland to win millions of dollars in business. **China's top economic planning agency is investigating the costs and prices of GlaxoSmithKline (GSK), Merck, Novartis and Baxter International.**

- * **Executives of GSK in China have confessed to charges of bribery and tax law violations of up to 3bn Yuan (R4,8bn).** Bribes were offered to Chinese government officials, medical associations, hospitals and doctors to boost sales and prices. GSK executives also used fake receipts in unspecified tax law violations. GSK said it was willing to co-operate with the authorities. Allegations that GSK staff had used improper tactics to market the Botox in China, are also being investigated.
- * GSK is one of the largest multinational pharmaceutical companies in China with a total investment of more than \$500m, according to its website. GSK made about £1bn in revenue in China last year.

- * **GSK performed 20 internal audits a year of its China operations even though it only constitutes 3% of its sales.** However, the fact that GSK did not detect fraud, bribery and corruption of this extent after undertaking its own internal investigations places doubt over the effectiveness of its internal control systems.
- * **Aspen Pharmacare had offered GSK about £700m (R10,5bn), to acquire two of its branded thrombosis medicines,** Arixtra and Fraxiparine, plus a specialised sterile manufacturing facility at Notre Dame de Bondeville, France. About 85% of injections produced there are destined for export to 87 markets.

Ascendis strengthens its listing chances

Business Day, 11 July 2013

Health products company Ascendis confirmed the acquisition of anti-ageing treatment company Solal Technologies and an investment to take a majority stake in pet health group Marltons. The company has consolidated its debt by securing bridging finance of R500m from Standard Bank and Sanlam. Another R350m in equity was obtained from its majority shareholder, Cape Town equity player Coast2Coast, and other investors. The latest acquisitions could push up Ascendis's revenue to more than R1,5bn a year.

Cipla aims to enhance empowerment opportunities; Cipla predicts strong growth in Africa; JSE-delisting

Business Day, 11, 12 July; Business Day, 12, 17 July 2013

Indian generic drugs maker Cipla will seek to increase the black economic empowerment (BEE) status of its SA business, following its R4,46bn acquisition of 100% of Cipla Medpro. Cipla Medpro's BEE partner, called Sweet Sensation, will no longer have black shareholders once the acquisition goes through. The firm's CEO, Subhanu Saxena, declined to discuss his company's BEE strategy. Cipla Medpro SA has had a long-standing relationship with Mumbai-based Cipla, which provides about 85% of the generic medicines it sells in SA. Saxena also predicted strong sales growth in Africa. He said analysts had predicted that the African pharmaceutical market would reach between \$30bn and \$40bn within seven years.

- * **Cipla delisted from the JSE on 16 July.**

7. GENERAL NEWS:

Smoke: WHO campaign not just hot air; Smoking down 33% among adults since ban on adverts

Cape Times, 17 July 2013

The ban on cigarette advertising has worked - and so will the mooted ban on alcohol advertising, according to National Council against Smoking's head, Yussuf Saloojee. Smoking among 15- to 16-year-olds had decreased by 26% since the ban in 2000 of cigarette advertising, and by 33% among adults. He said claims that the banning of alcohol advertising were ineffective and lead to a loss of jobs were unfounded.

- * The latest study - one of the first to look at the effects of the WHO's anti-smoking measures - found that by 2050 antismoking legislation would have averted 7,4m deaths and resulted in 15m fewer smokers. Looking at 41 countries that have adopted a package of evidence-based tobacco-control measures, known as MPower, between 2007 and 2010, researchers also found that tobacco control policies resulted in other health benefits such as healthier newborn babies and better birth weights. Health warnings alone reduced the number of smokers by almost 1,4m while it averted about 700 000 smoke-related deaths.

Surgery and safaris are a growing market; Weak rand bringing in more medical tourists

City Press, 21 July; Cape Times, 30 July 2013

Medical travellers in SA spend over R1,5bn annually - of which about 90% is generated by travellers from the rest of Africa. The cost of surgery in SA can be one-tenth or less of what it is in the US or Western Europe. Medical tourism includes medical procedures such as cosmetic surgery, cancer treatment, dentistry, fertility or rehabilitation. Many clinics offer packages that include personal assistants, visits with trained therapists, post-operative care in luxury hotels and safaris or other vacation incentives.

A lot of these travellers are middle-class Africans from East and West Africa seeking specialist diagnosis and treatment. More than 80% of the total medical travel flow to SA consists of formal and informal movements from neighbouring countries. The number of medical travellers is currently 300 000 to 350 000 per annum. Lesotho has the highest numbers (140 000), followed by Botswana (55 000), Swaziland (47 000), Mozambique (38 000) and Zimbabwe (17 000).

* **Experts believe the rise in 'medical tourism' is due to a weak rand.** Ingrid Lomas, chief executive of Surgical Attractions, agreed that the weak rand was responsible for the surge. According to a report from the Southern African Migration Programme, medical migrants from African countries spent more time in SA than European medical tourists. **Medical tourism could be the next big money spinner and the report predicted that private doctors would begin targeting medical tourists.** At present, medical tourism was a sideline for hospitals, clinics and physicians in SA's private healthcare system. However, as the revenue-generating potential of the medical tourism industry grew, dedicated health and medical facilities were likely to be established to cater for the medical tourist.

Concern over hospitals' use of starch drip

Business Day, 23 July 2013

The Medicines Control Council (MCC) is **reviewing the safety of starch drips, used to stabilise critically ill** hospital patients across SA. The MCC has the power to order them off the market, a move that would be particularly bad news for Adcock Ingram. Starch drips are used to build up blood volume in patients who are dehydrated or have lost a lot of blood. Last month, the UK's Medicines and Health Regulatory Agency suspended the use of starch drips over safety concerns, and The US Food and Drug Administration (FDA) and the European Medicines Agency have also taken steps to limit their use.

8. IN A NUTSHELL

State of US health 'mediocre'

Although Americans are living longer, with overall US life expectancy increasing to 78.2 in 2010 from 75.2 in 1990, increases in psychiatric disorders, substance abuse, and conditions that cause back, muscle and joint pain mean many do not feel well enough to enjoy those added years. In a 2010 report by the non-profit Commonwealth Fund, the **US, despite spending twice as much on healthcare, came in dead last compared with six peers - Britain, Canada, Germany, Netherlands, Australia and New Zealand.**

Critical illness claims lift insurance payouts

Three of SA's major insurers, **Liberty, Old Mutual and Sanlam, last year paid out at least R7bn in claims for life, disability and critical illness cover in SA.** Liberty paid out R2,3bn; Old Mutual paid out R2,2bn in life cover claims and Sanlam paid R527m in disability-related claims and R1,8bn for deaths.

Desperate poor selling body parts

According to Unisa professor Magda Slabbert's research on kidney transplants, recipients pay up to \$120 000 (R1m) to international organ brokers on the black market for the kidneys. Sellers were willing to accept \$5 000 to \$6 000 from brokers. She suggests discussion among governments around the world on the issue of regulating buying and selling of kidneys to curb the ever increasing black market trade.

Depressing mental health stats

One in five people in SA has mental health problems. By 2020 depression could be the second most disabling health condition in the world. However, there is no formal mental health policy, as the Act (promulgated in 2004) was an unfunded mandate. **SA morbidity data indicated that mental disorders were the third highest contributor to the local burden of disease** after HIV and other infection disorders. Almost 75% of people who lived with mental disorders in SA did not receive the care that they needed.

UCT scientists take big steps towards single-dose malaria cure

UCT scientists may be close to producing a single dose cure for malaria. The malaria-killing compound, named MMV390048, was discovered by a team in collaboration with partners from all over the world. In pre-clinical trials the compound killed the parasite in a single dose that was given to the subject orally.

Meanwhile the compound has been named Project of the Year for 2012 by Medicines for Malaria Venture.

Largest cancer gene database made public

Scientists from the US National Cancer Institute have released the largest-ever database of cancer-related genetic variations, providing researchers the most comprehensive way so far to figure out how to target treatments for the disease. To create the database, the NCI team sequenced 60 human cancer cell lines, generating an extensive list of cancer-specific variations for different parts of the body.