HEALTHMAN PRIVATE PRACTICE REVIEW: AUGUST 2016

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VIEW ON SPECIAL NEWS.

ECONOMIC FLIP SIDE OF NATIONAL HEALTH SCHEME

Summary: *Dr Johann Serfontein of the Free Market Foundation Health Policy Unit: BDlive, 16 August 2016*

The National Health Insurance (NHI) scheme promises "free healthcare for all". The concern, obviously, is that while *receiving* healthcare might be free, *providing* it is not - someone has to pay.
SA has 5,7-m taxpayers who would need to fund healthcare for about 55-m people including the 8,8-m medical scheme members who are currently self-funding their healthcare.
The NHI white paper postulates that a one-year improvement in a nation's life expectancy can increase GDP per capita by 4% in the long run. The concomitant GDP growth, however, seems to be absent to support this theory in the SA context. The most probable cause is the 38% broad unemployment rate, which remains unconsidered.
The NHI is a socialist system, but it has to be funded by capitalist taxpayers. According to the South African Revenue Service, 57% of SA's personal income taxes are paid by 480 000 high-earning individuals. The fact that medical schemes will cease to exist under the NHI and direct access to high-quality private healthcare is not a certainty in this system, must raise serious concerns among this group. Emigration is a financial possibility for this group, and a mere 200 000 emigrations could cut SA's personal tax revenue by a quarter.
With no provision made for private spend in the NHI white paper, the economic effect of not spending R162-bn on private healthcare would reduce GDP by R170-bn, a 4,2% reduction. Simply doing the required assessment of the socio-economic impact of the policy would prove it untenable, and the energy and resources being spent on planning for the NHI could be spent on finding a viable alternative.

PROBING INTO PATENTS AND NEW DRUGS

Summary: *Marcus Low, former director of policy: Treatment Action Campaign*: *Business Day, 23 August*

According to the Drugs for Neglected Diseases Initiative (a non-profit group) a new drug on average costs less than $200-m to develop (including cost of failures). At the other end of the spectrum the Tufts Centre for the Study of Drug Development claims the costs could run up to $2,6-bn. Another figure suggests between 8% and 18% of revenue, much less than is spent on marketing, and also less than profits.

It is both reasonable and appropriate that as part of the deal when granting pharmaceutical firms patent "rights", governments should demand transparency on how these are exploited. While few will object to pharmaceutical companies making reasonable profits and no one wishes to slow the discovery of new medicines, this does not mean we have to be kept in the dark.
If there are policy, regulatory or legal interventions that will increase people's access to medicines without threatening new discoveries, we must consider it.
Public interest demands it, and lives depend on it.

NEXT HIV PLAN NEEDS TO BE BASED ON LATEST EVIDENCE

Summary: *Marcus Low: Health-e News Service: 1 August 2016*

At the end of this year, South Africa's big plan to fight HIV and tuberculosis (TB) comes to an end. The National Strategic Plan (NSP) for HIV, TB and STIs 2012 - 2016 will be replaced by the 2017 - 2021 NSP. Government's tendency to forge ahead with little regard to AIDS councils undermined the vision of a wider societal AIDS response drawn together by the NSP and AIDS councils.
Top six priorities in the next NSP:
In order to deal with these problems and to provide for a more focused and effective NSP the following should be considered for the NSP 2017 - 2021:
1. We need real-time monitoring of the healthcare system
2. We need a roadmap to treatment for all
3. We need an ambitious plan for TB
4. We need an ambitious and evidence-based HIV prevention plan
5. We need concrete plans to bring in business and labour
6. We need to fundamentally reform SANAC

THE PITFALLS OF SOME CHEAP HOSPITAL PLANS

Summary: *Susan Erasmus: Fin24, 21 August 29016*

Make sure exactly what you are covered for, and what not:
* 100% of fund/scheme rate. The fund or scheme rate can be significantly lower than the costs of the hospital or the private doctors in the hospital. This is why it might be advisable to pay a bit extra, and get a hospital plan that covers you for 200% of the fund/scheme rate - and also consider getting gap cover.
* No overall annual limit. All high-cost cases are monitored by schemes in order to protect the interests of other members and the solvency of the fund
* Network hospitals to be used. If you don't use a network hospital for a planned procedure or you don't get a hospital admission number, your plan does not have to cover you at all.
* Co-payment on admission. Some low-cost hospital plans require a co-payment on admission for anything except motor vehicle accidents, emergencies and admission to the maternity ward
* Network Day Clinics to be used for certain procedures. C heck the list
* Chronic medication subject to scheme formulary: All hospital plans have to pay for medication for 27 PMB Chronic Disease Conditions, but many of them have a rand value attached or a list of specific medications that it will pay for.

* Payment for prostheses. Some of the cheaper hospital plans will only cover prostheses that are PMBs, or they have a maximum amount.
* Psychiatric treatment. There is often a lump sum allowed per family for psychiatric treatment.
* Co-payments on certain procedures.
* Oncology cover. Many cancers are not PMBs, and many cancer patients are day patients. Hospital plans often have a fixed amount set aside for cancer treatment.
* Take-home medicine. Technically medication you take after returning home is for your own account if you only have hospital cover. Some hospital plans will pay for a fixed number of days of take-home medicine, others may restrict you to a rand amount - and others may pay nothing. Follow-up visits to the doctor after your release from hospital can also often be for your own account.
* MRI and CT scans are often done as part of a process to diagnose your condition and they are not covered by most hospital plans.
* Hospice care. Often limited to a rand amount, or to a number of days (some are as few as 10).

VIEW ON GOVERNMENTAL DEVELOPMENT

BACKLOGS PREVENT SUBMISSION OF COMPENSATION FUND'S REPORT;

The Compensation Fund for Mines and Works' 2015-16 financial report cannot be submitted within the timeframe laid down by Parliament because of backlogs in the capturing key data, said Health Minister Aaron Motsoaledi. About 100 000 claimants had unpaid claims; about 45% dating back to 2000.

COSMETICS INDUSTRY TO GET A MAKEOVER IN SA

Health Minister Aaron Motsoaledi plans to roll out new regulations for the labelling of cosmetics in SA. Among the proposed amendments are that manufacturers, packers, distributors, importers or any person on whose behalf a cosmetic is packed, must refrain from making claims such as "clinically proven" or "recommended by doctors" without evidence to substantiate the claims.

RAF PREVENTS FRAUDULENT CLAIMS WORTH R126-M

The Road Accident Fund (RAF) has identified bogus claims to the value of R126-m made between April and June 2016. The claims were detected before they were paid out. Of the 108 bogus claims that were detected, 100 were claims represented by attorneys.

VIEW ON NEW PRODUCTS

NEW COMPANY TO FIGHT DISEASES

Glaxo Smith Kline and Google parent Alphabet's life sciences unit are creating a new company focused on fighting diseases by targeting electrical signals in the body, jump-starting a novel field of medicine called

bioelectronics. Verily Life Sciences - known as Google's life sciences unit until last year - and Britain's biggest drug maker will together contribute £540-m over seven years to Galvani Bioelectronics. The new company is owned 55% by GSK and 45% by Verily.

CANCER FIX UNDER THE MICROSCOPE;

The doctors, who run care company Isimo Health, have launched a registry to collect real-time data from patients who receive one of five high-cost drugs to get a better understanding of who responds to the medication. The drugs cost between R500 000 and R1-m a treatment.

HIT-AND-MISS MEDICINE IS GIVING WAY TO TAILOR-MADE DRUGS

The rise of "personalised" or "precision" medicine is revolutionising the way doctors and pharmaceutical companies approach disease. Using genetic sequencing, medical professionals are now able to separate people with similar symptoms into far narrower groups and target medicines at them.

VIEW ON MEDICAL SCHEMES (CMS Circulars)

STATE MEDICAL AID MAY GO BUST

The Government Employees' Medical Scheme (Gems) could be insolvent by financial year-end if drastic cost-containment measures are not instituted. Internal documents show if the current trend continues, the scheme's deficit for 2016 could increase to R1,2-bn, and its reserves could fall as low as 2%.
* From October 1, Gems plans to implement waiting periods for previous and new members.

BONITAS TAKEOVER OF LIBERTY HEALTH GETS NOD

The Competition Tribunal has approved the merger between Bonitas Medical Fund and the ailing Liberty Medical Scheme without conditions

MEDICAL SCHEMES GET STICK FOR BRAND ABUSE

According to the CMS some administrators are abusing their access to consumers to sell them services from other companies within their group. Among the firms are Discovery Health and Momentum Medical Scheme Administrators. A draft undesirable business practice declaration was published in the *Government Gazette* on August 15. It proposes declaring it an undesirable business practice for an administrator to use its communications with members to promote products or services not directly related to the business of the scheme.
http://www.gov.za/sites/www.gov.za/files/40209_gon917.pdf Tamar Kahn:

CALL FOR MEDICAL BENEFITS PROBE

The SA Society of Psychiatrists (Sasop) and the Psychiatry Management Group (PsychMG) called for a change in prescribed minimum benefits (PMBs) to offer full cover for all mental health illnesses.

SCHEMES MUST INFORM MEMBERS IF THEY REDUCE BENEFITS;

Consumers would lodge significantly fewer complaints about their medical schemes if schemes communicated openly with them, as was required by the regulations under the Medical Schemes Act, according to Tembekile Phaswane, the senior manager for complaint adjudication at the CMS.

75% IN WESTERN CAPE WITHOUT MEDICAL AID;

According to the Western Cape health department 75% of people in the province are currently without medical aid cover. The province is moving away from only treating illnesses and would now be focusing on wellness to help those uninsured. The department has a R20-bn budget to treat its 6.30-m people.

COUNCIL FOR MEDICAL SCHEMES: CIRCULARS

CLINICAL COMMITTEE FOR GASTROINTESTINAL CANCER (52 of 2016)

The CMS called for nominees to participate in the clinical committee for the benefit definition project for gastrointestinal cancers (GIT) to be submitted by 30 August to:
pmbprojects@medicalschemes.com

ORGANISATIONS ACCREDITED FOLLOWING EXCO MEETING (53 of 2016)

The CMS announced the renewal of accreditation of the following organisations:
Providence Healthcare Risk Managers (Pty) Ltd for 20 years with conditions.
Samwumed renewal of compliance with the standards applicable to self-administered medical schemes.
Prime Med Administrators (Pty) Ltd: Accreditation after change in control.

GENESIS PRINCIPAL OFFICER (54 of 2016)

The CMS confirms that Mr. Dennis van der Merwe and not Mr Brian Watson is the duly appointed Principal Officer of Genesis Medical Scheme.

QUARTERLY STATUTORY RETURNS (period ending 30 Jyne) (55 of 2016)

The online programme for statutory return users (Quarter2) is available at
https://www.medicalschemes.com/returns/login.aspx
The following signed documents must be physically submitted to CMS by 9 September 2016:
2x quarterly return documents (DD/MM/YYY);l
2x sets of monthly management accounts; and
Detailed investment schedules.

For guidelines on categorisation of assets: refer to website
http://www.medicalschemes.com/Publications.aspx

NDUCTION PROGRAMMES FOR TRUSTEES (56 of 2016)

A two-day consultative workshop for newly appointed members of the Board of Trustees for medical schemes by the CMS will be held in Gauteng 22 - 23 September and in the Western Cape 13 - 14 October
Programme includes:
Introduction to the Medical Schemes Act
Compliance with the Medical Schemes Act
Prescribed Minimum Benefits
Accreditation of Brokers, Administrators and Managed Care Organisations
Complaints and administration\judication
Financial Soundness of Medical Schemes
(CPD points for attending the workshop)
To register: **www.medicalschemes.com** and click on relevant link

AMMENDMENTS TO REGULATIONS 31 an 32 of MEDICAL SCHEMES ACT (57 of 2016)

Amendments regarding Regulation 31&32: The effective date of the amendments will be made known in the published *Government Gazette* and the CMS will communicate the details, once available.

AUDITOR APPROVALS (58 of 2016)

Applications for auditor approvals for the 2016 financial year are available on the CMS website www.medicalschemes.com
Medical schemes are requested to confirm the following information with the CMS:
Name and surname of scheme users authorised to access the 2016 portal
Confirm details of all the scheme users annually (send to h.mahlake@medicalschemes.com)
Usernames and passwords to access statutory returns will allow users to access the approval portal
New users should register on the Statutory Returns portal of the CMS website
Submission requirements:
Complete applications online and deliver all submission documents physically to the CMS before the due date (28 August)
Schemes failing to present the Registrar of Medical Schemes with the prescribed documentation shall be liable to a penalty for R1 000 calculated daily for as long as the scheme fails to comply.

PUBLISHING OF UNDESIRABLE BUSINESS PRACTICE DECLARATION (59 of 2016)

The Registrar issued a revised draft (Undesirable Business Declaration (Notice 917 of 2016) declaration for publication in the *Government Gazette* (15 August)
Written comments should be submitted within 21 working days of the publication to
t.diniso@medicalschemes.com

REQUEST FOR MEDICAL MALE CIRCUMCISION DATA (60 of 2016)

The National Department of Health has embarked on a five year Medical Male Circumcision (MMC) programme, collecting data mainly from public health facilities. This has been extended to include data from private health facilities (MMC data for 2014 and 2015 from medical schemes).
The CMS will be collecting MMC (events and costs) data from medical schemes.
Schemes are requested to submit MMC data to the CMS before 26 September 2016
The correct data template is available at
http://medicalschemes.com/files/extras/MMCDataSpe20160825,xlsx
All data should be sent to MMC@medicalschemes.com by 26 September 2016
More information from Kgotsofatso Phaswana**: k.phaswana@medicalschemes.com**

SPECIAL NOTICES

No special notices were received