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**Titration**

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<th>CONCERTA®</th>
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* Newly diagnosed patients: Start at 18 mg daily, titrate up to optimal dose


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Dear colleagues

The Supreme Court of Appeal (SCA) on Thursday the 20th of September denied the BHF and SAMWUMED the right to appeal against the dismissal of their application for clarity on PMBs and Regulation 8. The SCA did not give reasons for its decision, but said its dismissal of the application for leave to appeal signified that the court is of the view that the appeal would have no prospects of succeeding. This was also the view expressed by Judge Cynthia Pretorius in the Gauteng North High Court application to appeal.

This matter has now been heard in the High Court, gone on Appeal in the Gauteng North High Court and on further appeal to the Supreme Court of Appeal in Bloemfontein. We believe that millions of rands have been spent on legal costs alone in pursuing this matter. The BHF Board is accountable to their member schemes and ultimately scheme members for this money wasted. There is also still a cost order against BHF that they will have to deal with.

SAPPF once again thanks its members and member organisations who support SAPPF and who was one of the main opponents to this frivolous application by the BHF.

SAPPF reminds its members that as a general rule, all costs relating to the diagnosis and treatment of PMBs should be paid at cost, unless certain managed care tools such as Designated Service Providers and Formularies are applied by a Medical Scheme. Scheme members should also be educated by their doctors in this regard to ensure that they receive the relevant PMB benefits that they are entitled to.

Regards

Chris Archer
CEO

Supreme Court Rejects BHF Appeal On Regulation 8

SAPPF

South African Private Practitioners Forum
The previous edition was released shortly after the postponement of the controversial publication of the HPCSA Interim Tariffs for Medical and Dental Services. To recap briefly – the issue of controlled tariffs was always on the political agenda, but the proposed publication of the guidelines caused immediate shock and anger amongst professionals when it was realised that the HPCSA had taken the industry back nearly a decade, to the 2006 NHRPL, but with an inflator of 46.44%.

Fortunately, the profession – in the form of the SAPPF/ SAMA and SADA – responded expediently and after a series of emergency meetings, the HPCSA withdrew the proposed publication. In the aftermath of this ‘victory’, it was realised that there now exists an opportunity to put forward a strong case for the establishment of an equitable and transparent tariff determining process; one capable of creating a tariff for medical and dental services that will be affordable to our patients and reasonable for doctors and dentists, and one which will enable the provision of a modern service of good quality.

More recently, the Supreme Court of Appeal denied the BHF and SAMWUMED the right to appeal against the dismissal of their application for clarity on PMBs and Regulation 8 – “PAYMENT IN FULL legislation”. The Supreme Court did not give reasons for its decision, but said its dismissal of the application for leave to appeal signified that the court was of the view that the appeal would have no prospects of succeeding.

This matter has now been heard in the High Court, gone on Appeal in the Gauteng North High Court and on appeal to the Supreme Court of Appeal in Bloemfontein. In most countries, this should represent the end of the road for the BHF and its allies in this matter, yet this may not be the case as was made evident by the Health Minister Dr Aaron Motsoaledi, who delivered the keynote address at the SA Hospital Association Conference in Cape Town from 19-21 September.

Minister Motsoaledi stated: “I am painfully aware that the word ‘regulation’ is a swear word to many within the sphere of private healthcare. It is regarded as undue interference from an ineffective state that is failing to understand the laws of economics or a state that is desperately trying to divert attention from the problems of the public healthcare system by focusing unnecessarily on private healthcare. Some have argued that everything about private health must be left to market forces and the state must stay out of it. Those who think so will wake up to discover that this is no longer the direction that many health authorities are following around the world. There is realisation that it is very risky, and often when the risk matures into crisis, like the 2008/9 global economic meltdown, the state is then accused of poor stewardship and of failing to act.”

He pointed to the fact that while healthcare funders have been regulated over the years, this has ‘left the providers free to do whatever they wish and whenever they wish to’. Motsoaledi added: “This state of affairs, whereby one stakeholder is strongly regulated but the other stakeholder is left free, has resulted in the country being unable to balance the equation of healthcare financing. You won’t do justice to the healthcare system of the country if you don’t come up with a clear position on the issues of regulation and financing.”

If we refer to the comments made by the SAPPF and its allies after the HPCSA ‘victory’ - there now exists an opportunity to put forward a strong case for the establishment of an equitable and transparent tariff determining process; one capable of creating a tariff for medical and dental services that will be affordable to our patients and reasonable for doctors and dentists, and one which will enable the provision of a modern service of good quality – how can the individual practising PMG paediatrician impact the progress?

It all comes down to what the PMG EXCO has been stating for some time now. As mentioned at the Fancourt meeting by Caspar Venter, it is critical to decide upon a tariff that is appropriate for Practice Cost reimbursement. The temptation to sign DSP agreements must be avoided at all costs as these agreements could lead to the very downfall of the profession and an inability to negotiate in the immediate future. It is all too obvious what happened to Snow White when offered the apple...
By Dr Simon Strachan

The congress of The South African Paediatric Association (SAPA) was held at The Protea hotel, The Ranch outside Polokwane from the 22nd – 26th of August 2012. The SAPA congress is a bi-annual congress but was not held in 2010 due to the fact that the International Paediatric Association Congress was held in Johannesburg that year. So it was with determination and great expectation that The Department of Paediatrics of the University of Limpopo, The Medunsa campus, under the leadership of Prof François de Villiers accepted their turn as the host University.

The decision to hold the congress outside of a major centre was the wish of the host University. As Prof de Villiers said: “We work in the countryside so let’s have the congress in the countryside.” The theme was Bana Pele and this means “The Children First” and encourages us to always remember that in spite of the latest research or the newest drug or fancy piece of equipment we must not lose sight of the basic needs of our patients, the children.

The academic programme was presented as three parallel sessions over 5 days and this was only possible because many of the sub-speciality groups responded to the request to join the congress and arranged outstanding sessions. These groups included: USANA (Neonatology), PAEDS-SA (Endocrinology), PANDA (Neurology), Critical Care, FIDSSA (Infectious diseases), Rheumatology and Child Health. There were also fantastic programmes on Substance Abuse, Obesity, Pain Management, Vaccinology, Adolescent Health, Ventilation and Nutrition. The congress ended with a very interactive session on ethics and specifically the ethics of vaccination and ethics around management dilemmas at the limits of viability.

We had three International speakers who presented at the plenary sessions. Prof Catherine Weil-Olivier, Professor of Paediatrics, Paris VII University, gave a presentation on her work and the European experience with conjugate vaccines. Prof Atul Singhal, head of the Childhood Nutrition Research Centre, Institute of Child Health, University College, London presented on Childhood Obesity: Causes and Consequences. In a very colourful lecture he reminded us that we are actually what we eat. If we are aware that childhood obesity leads to adult obesity we can prevent the epidemic of non-communicable diseases affecting adults by ensuring that we pay attention to the weights, diets and exercise patterns of children.

The trend is for children to eat more calories and exercise less now, than they did one decade ago and we are in a prime position to educate them and their parents. Prof Alistair Fielder, Professor Emeritus of Ophthalmology, City University, London, presented current thinking and trends in preventing and treating retinopathy of prematurity. He demonstrated the improvement in the accuracy of diagnosis made possible by the Retcam and encouraged us to be aware of and to follow, the local guidelines for the screening of Retinopathy of Prematurity.

Prof Mignon McCulloch presented a tribute to the Paediatricians of yester year who made a significant impact on South African Paediatrics. Many a memory was jogged and a sentimental moment experienced. It highlighted once again the great advances made in the latter half of the 1900s.
In the opening plenary session Mr Anthony Ambrose from World Vision South Africa highlighted the current situation in this country regarding the health of our children; the high infant mortality rate, the deaths due to preventable diseases and the crimes committed against children. He pleaded that we should "listen to the cries of the children" and focus on the first 1000 days of a child's life. Prof Ann Skelton, a human rights lawyer specialising in children's rights, explained the current legislation around a child's rights and access to health care and stated that: "Children should have a preferential right to healthcare that should be immediately enforceable. We should be fighting for and vociferous about this." Prof de Villiers encouraged us to do something to make a difference by reminding us about the Skukuza declaration.

This was a declaration drawn up by the congress delegation the last time Medunsa hosted the SAPA congress 18 years ago. In it, certain goals and aspirations were written and these included: the eradication of polio, reduction in measles and tetanus by the year 2000, changing government policy around access to health care and introduction of the integrated management of childhood illness. Some of these goals have been achieved, but many were not and since then we have had the introduction of the millennium development goals. He urged that perhaps it is time for South African Paediatricians to sit down and produce version two of this declaration. The three speakers in this session spoke directly to Bana Pele – The Children First.

In response to Prof De Villiers' suggestion we asked delegates to write down practical ideas that could be implemented to enhance the lives of the children we serve or the children with whom we come in contact. This we called "Positive Pro Active Position" and these suggestions will be tabulated and circulated to all SAPA members. Members will then be encouraged to voluntarily pledge to take up one of these suggestions in their own practice.

The Registrar's session was a new concept that Prof de Villiers started at this congress. Every registrar has to produce a research paper in order to qualify as a Paediatrician so it makes sense to provide the registrars with a platform at which they can present their work. SAPA sponsored two registrars from each university if the registrars were presenting research papers at the congress. 11 papers were presented and prizes were awarded for the best oral presentations.

Best oral presentations by a registrar:

Dr Y Reddy – Characteristics of children presenting with newly diagnosed Type 1 Diabetes.

Dr E Kalimba – Outcome of extremely low birth weight infants at Charlotte Maxeke Johannesburg academic hospital.

The oral and poster presentations of new research were very sparse and this was certainly disappointing for the scientific committee. The quality of the research however was certainly not sparse.

The winner of the best oral presentation was:
Dr N. Kaponogo presenting on his Neonatal outcomes in a rural hospital.

The winner of the best poster presentation was:
Dr K Asharam: Ambient Pollution and Birth Outcomes.
The programme also offered sessions where the content was presented in a slightly different fashion from a didactic lecture. The obesity and the substance abuse sessions ended with the delegates divided into groups and each group having time with the speakers and discussing issues openly. The ECG and X-ray session was conducted in a keypad quiz format. This was well attended and Prof Andronikou presented on the chest X-ray diagnosis of TB. This is a talk that he has developed to train people, not only doctors, to diagnose TB accurately on X-ray. It will be used by groups such as Médecins Sans Frontières. Prof Fari Takawira spent the next hour leading a quiz on cardiac diagnosis and reminded us all about cardiac imaging as well as cardiac features on X-ray and ECG abnormalities.

Prof Andrew Argent and Dr Despina Demopoulos presented an afternoon workshop on ‘Ventilating the Paediatric patient’ and this gave the participants the opportunity for hands on experience with the ventilators and artificial lungs provided by RCA. Sr Ruth Loubser spoke in the General Paediatric session on Early Childhood Embodiment – Enabling resilience from the start. During this lecture she encouraged us to empower the parents of our young patients to openly discuss sexuality with their children. We need to be ensuring that our children are aware of their own sexuality from a young age. We need to make it part of examining every child to examine the genitalia and talk to the child in the confines of the examination room about sexuality and sexual awareness.

Delegates who were present on the Friday night had the opportunity to participate in the social outreach programme. The organising committee had the notion to leave a footprint in the rural area in which the congress was held. This was achieved by partnering with STOP HUNGER NOW. This organisation provides the raw ingredients and the infrastructure for meal packing. The congress delegates and the Pharmaceutical company reps packed 15 000 meals in 90 minutes and these will be provided to a small crèche of 46 children in a village not far from the congress venue. This crèche does not qualify for local government subsidies.

The school is called the Jonas Kgapo school. The meals will feed the children for 6 months and the school will in turn commit to a small improvement project which will be funded by the money that they save by not having to buy food for 6 months. During the congress the delegates had the opportunity to pledge money towards helping the school. Through personal donations and a donation from Pharma we raised R17 000 which will be used to provide for the school’s most urgent need which is piped water. Bana Pele - The Children First.

Taking the congress to the countryside was bold and was perhaps one of the reasons why the attendance was less than expected. In total 161 doctors attended the congress in the most beautiful surroundings. They had the opportunity to walk with lions, go on game drives, relax in the fantastic gardens or by the pools in beautiful weather and participate in an excellent academic programme. The social events were very social indeed and enthusiastic dancing and partying was accompanied by excellent music. All in all we had a very successful congress and our thanks are extended to all the Pharma companies that supported SAPA so generously. Thanks to all the speakers and all the delegates who will definitely remember Bana Pele.
OMEZ is indicated in children ≥1 year with severe ulcerative reflux oesophagitis:

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<tr>
<th>Weight</th>
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<tr>
<td>10-20 kg</td>
<td>10 mg once daily. If needed increase to 20 mg once daily</td>
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<tr>
<td>&gt;20 kg</td>
<td>20 mg once daily. If needed increase to 40 mg once daily</td>
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There is very limited experience with the use of OMEZ in children.

Dr. Reddy's Laboratories (Pty) Ltd. Reg. No. 2002/014163/07, Tel: +27 11 324 2100 www.drreddys.co.za
A child in the first year of life breathes through the nose. This means that the only way a child can breathe comfortably is if the nose is clear and not blocked. The nose connects the 4 sets of sinuses and the ears by little tubes and this creates a structure of many little passage ways. This is important because this system helps to clean and humidify the air we breathe so that the air that gets to the lungs is clean and warm.

The nose and sinuses produce mucus that traps the dirty particles in the air and little hairs along the passage ways beat in time to clear the mucus.

The nasal passages of a child are very small and they find it difficult to clear even the mucus that is normally produced in the nose. They are also not able to blow the nose so they frequently sound like they have a blocked nose. Flushing the nose with sterile saline is safe and very useful to clear the nose.

The Common Cold
This is a viral infection due to a virus called Rhinovirus and is very common especially in the winter months. The whole infection lasts about ten days and starts with a blocked nose and sore throat for about three days and then the nose starts to run, a cough develops and your child may develop a slight fever. This continues for another five to seven. The nasal blockage is usually worse at night when the child is lying down.

The runny nose usually starts when the cold is starting to get better. When the cold virus (Rhinovirus) first infects the nose and sinuses, the nose starts making lots of clear mucus. This mucus helps wash the virus out of the nose and sinuses. After two or three days, as the body fights back, the mucus changes to a white or yellow colour. As the bacteria that usually live in the nose grow back, they change the mucus to a greenish colour. This is normal. It doesn't mean your child has an infection that needs to be treated with medicines like antibiotics.
The Common Cold

Why not take antibiotics for The Common Cold?
Taking antibiotics that your body doesn’t really need can be harmful. After each antibiotic, your child is more likely to have resistant germs in his or her nose. If your child gets infected again, it’s more likely to be with these resistant germs. Resistant germs aren’t killed by the usual antibiotics. If your child gets infected with a resistant germ, it might be necessary to use more expensive and powerful antibiotics or even antibiotics that have to be given in the hospital. Since a runny nose generally gets better by itself, it’s best to wait and take antibiotics only when necessary.

How can I treat The Common Cold?
Runny nose, cough, fever, headache and muscle aches may bother your child during a cold, but medicine won’t make them go away faster. Using a cool mist vaporizer or giving your child an over-the-counter nasal decongestant in the form of a nose drop or nose spray, may help. It is very important to note that the nasal decongestant must not be used for longer than a week at a time. Using them for longer periods of time will cause the nose to block up when the medication is stopped.

The most important part of the treatment is to ensure that the nose is clear and that the child is taking fluids and feeds.

The use of combination cough and cold medications are not safe in children under 2 years of age and they should not be used. They have no benefit in the treatment of a cold as they do not help your child to get better faster. Over the counter cough and cold remedies have side effects such as disturbed sleep, unusual movements & hallucinations. Check with your doctor to see which medicines are okay to use.

When is it more than a Cold?
The Common Cold follows this 10 day course and is generally not a serious illness although the nasal congestion and cough can be very troublesome especially for young children. Despite the nasal congestion they do not have difficulty breathing if the nose is cleaned out. If you watch your child breathing you will see that there is no sucking in between the ribs or under the ribs with breathing and there is no rapid breathing. Breathing is not an effort for them.

Warning sings of the Cold being something else!
- A fever of >38.5°C lasting for more than 2 days
- Poor feeding when the nose is clear
- Vomiting or diarrhoea
- Difficulty breathing and rapid breathing
- Noisy breathing: grunting, whistling or wheezing
- Overly sleepy or listless

This information provides a general overview on Coughs, Colds & Snotty Noses and may not apply to everyone. Talk to your family doctor to find out if this information applies to you and to get more information on this subject.

www.paediatrician.co.za
The inordinately high incidence of road traffic accidents in South Africa contributes significantly to neurological injuries in children. This, together with near-drowning, violence, accidental injuries, certain medical conditions and, to a lesser degree, birth trauma, result in many children being affected with varying types and degrees of neurological challenges.

Why paediatric rehabilitation?

A number of factors necessitate a different approach to the rehabilitation of children compared to that of adults. One such factor is brain maturity, with a child's brain still in the process of growing and developing through an active process of learning and acquiring new skills. The occurrence of brain injury resulting from illness or injury can severely affect a child’s ability to achieve normal milestones.

Research evidence indicates that starting rehabilitation as early as possible is important in optimising recovery of brain function and reducing the level of short and long term impairment and disability. In the enriched environment created through paediatric rehabilitation, the child is stimulated to successively achieve age-appropriate skills.

Dedicated and intensive inpatient rehabilitation of children also serves to provide a supportive and informative environment for parents, other family members and caregivers, who usually struggle to come to terms with the trauma that paediatric disability brings about.

Benefits of paediatric rehabilitation

The benefits of Life Rehabilitation’s programme include the following:

• Prevention of prolonged stay in an inappropriate, acute hospital environment.
• Improved outcomes achieved over a shorter, focused period of time.
• On-site rehabilitation service offered by a comprehensively trained, interdisciplinary team of medical, nursing and therapy professionals, who address all issues.
• Child and family- centered, outcomes driven rehabilitation.
• Simulation of the home environment where the child has the opportunity to practice tasks with increasing confidence.
• Focused and appropriate caregiver training by all team members.

Paediatric rehabilitation programme

Life Rehabilitation’s paediatric programme is focused on providing time limited, patient-centered, cost effective and outcomes based intervention early in the recovery process. This approach ensures that all medical, physical and psycho-social needs are addressed timeously for an optimal outcome. The holistic, interdisciplinary programme includes both individual and group sessions. Individually targeted intervention is developed for each child, based on a variety of standardised and internationally recognised assessments, which cover functioning across the spectrum of functional areas. Interdisciplinary team meetings are held weekly to assess the child’s progress and, based on this a decision is taken on whether any adaptations to the programme are necessary.

The following interventions form part of the programme:

• Neuro-developmental therapy to facilitate appropriate function.
• Facilitation of speech and safe swallowing.
• Cognitive therapy.
• Psycho-social intervention.
• Continence retraining, where needed.
• Facilitation of appropriate seating systems.
• Facilitation of appropriate splinting.
• Implementation of play and leisure activities.
• Establishment of a home programme.
• Assessment of scholastic ability and recommendation for future scholastic intervention.
• Facilitation of access to appropriate disability resources.
• Referral to appropriate resources for continued therapeutic intervention after discharge.
• Follow-up assessment to ensure maintenance of functional development.

The following services are provided by the interdisciplinary team:

• Daily doctor visits.
• Nursing care by skilled rehabilitation nursing professionals.
• Individual physio, occupational and speech therapy as required, designed to stimulate optimal outcome.
• Group therapy.
• Dietary services.
• Psycho-social support and intervention on therapeutic and clinical levels.
• Patient and family education and support.
• Education, training and support of primary caregiver by all team members, if required.

Which children could benefit from paediatric rehabilitation?

• Children (under 12 years) with acquired neurological conditions, for example traumatic brain injury, spinal cord injury or Guillan Barré syndrome.
• Children with cerebral palsy, who have limited access to appropriate therapy resources.
• Children with degenerative conditions, such as muscular dystrophy.

Life Rehabilitation’s specialised paediatric programme has been developed to help restore affected children to their fullest physical, mental, emotional, social, scholastic (and eventually vocational) potential possible. Success in this restoration results in reduced healthcare costs and burden of care in the long term, and improved quality of life.

Our quality

Our Life Rehabilitation units meet the international ISO-9001:2008 standard of quality management systems. We are the only rehabilitation group certified in this standard in South Africa. This means that our risk management, general operating processes as well as quality management systems are of international standard and undergo rigorous testing through both internal and external audits to ensure this is maintained.

Standardised guidelines and best operating practices have been implemented in order to mitigate any risks related to both client and employee incidents. These incidents are monitored monthly, quarterly and annually, and tracked, trended and managed. It forms the core to our delivery of quality services. Having done this since our inception this sets us as the market leaders in this regard.

Client satisfaction is measured by state of the art electronic devices which collate data and provide feedback to our units for their management. We take pride in the fact that the vast majority of our clients report that they are satisfied with our service and that we take any negative client feedback very seriously, using it as an opportunity for improvement by implementing changes where necessary.

Outcomes Based Rehabilitation

To ensure maximum progress, the patient is regularly monitored and assessed using internationally researched and recognised methods including the weeFIM™ (Functional Impairment Measure) for paediatric clients, which is central to goals-driven and outcomes-focused therapy. This process:

• provides a useful baseline overview and measurement of a patient’s impairments;
• informs the rehabilitation team, the patient and family of the potential that can be reached;
• helps set goals;
• forms the basis of progress reports sent to referring doctors and funders; and
• ensures clinical excellence and constant improvement of our teams.

Our paediatric rehabilitation units are legally licenced to use the weeFIM™. They undergo bi-annual accreditation in order to maintain this licence.

For more information please contact us at the following details:

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Tel: 031 204 1300 (ext 360)
Fax: 031 261 3439
E-mail: rehab.entabeni@lifehealthcare.co.za

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E-mail: rehab.headoffice@lifehealthcare.co.za

Website: www.rehab.co.za
“EARLY CHILDHOOD EMBODIMENT” – enabling sexual resilience from the start!

By Ruth Loubser RN RM, Sexual Health Educator
(in private practice)

INTRODUCTION

Historically, sexuality has been limited to ‘reproductivity’ and the social rules that govern this. Sex education has consequently been limited to pathology prevention (teen pregnancy, STI/HIV) or moral socialisation of youth. ‘HIV’ education and ‘abstinence only’ programmes in following these historical tangents have not only failed to achieve their medical and moral goals, but have failed to take the whole person and context into consideration. Guilt, shame and silences around sexuality further complicate the situation and parents, already fearful of ‘sex education’, slip further into avoidance or abdicate this responsibility to peers, teachers or TV.

In a country with rampant sexual abuse and where personal moral agency, especially of women and children is limited, the question needs to be asked, ‘Are these key messages valid for all cultures’? A framework has value but will be nothing more than ‘key messages’ for specific stages of sexual development, are a useful point of departure, but fall short if they are not tested in ‘real life’ situations.

My aim in sexuality education is to enable resilience and well-being of the whole person. My philosophy of ‘Body Ubuntu’ acknowledges the rights of all to dignity and care. The moral obligation of all community elders (including doctors), is to empower the child to ‘know, own and protect’ their body from an early age. This posture visualises the potential of the child to participate in health conversations and intentionally calls forth the ‘voice’ of the child through both verbal and non-verbal communication.

As specialists in private practice you are one of the first role-models the child will have of someone in a position of power over their bodies. I believe that you are uniquely positioned to play a constructive role in providing a supportive environment for early childhood sexual education. This will enable the parents to rise above their own fears and insecurities, and claim their rightful place as sex educators in their own homes.

This paper will define sexuality, tell a ‘toddler story’ where two cultures collided, and then use this to further unpack early sexual development and the needs of both children and parents. Some practical suggestions will be offered for both non-verbal and verbal communication around sexuality within a private practice. Some controversial sexual topics will be noted as evidence of this unfolding dynamic field.

1 Moran, JP. 2000. Teaching Sex – the shaping of adolescence in the 20th C. Harvard University Press

SEXUALITY - Beyond Babies!

Various sources have sought to define sexuality – with difficulty! Below is one fairly comprehensive definition, followed by the

SIECUS (Sexual Information and Education Council of the United States) framework.

Definition of Sexuality (Promotion of Sexual Health – Recommendations for Action WHO/PAHO, in association with the World Association of Sexual Health – May 2000)

Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. While sexuality can include all of these aspects, not all of these dimensions need to be experienced or expressed.

However, in sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

A SEXUALITY FRAMEWORK FROM SIECUS (www.siecus.org)

1. Human development: Reproductive anatomy and physiology, reproduction, puberty, body image, sexual identity and orientation.
3. Personal skills: Values, decision-making, communication, assertiveness, negotiation and looking for help.
5. Sexual health: Contraception, abortion (termination of pregnancy), sexually transmitted infections, including HIV infection, sexual abuse and reproductive health.
6. Society and culture: Gender roles, sexuality and the law, sexuality and religion and diversity.

Sexuality and the arts, sexuality and the media

This framework has been widely used in various circles to shape ‘key messages’ for sex education in various stages of development. A task group worked on a comprehensive document, Right From the Start: Guidelines for Sexuality Issues (Birth – 5 yrs). Yet, the question needs to be asked, ‘Are these key messages valid for all cultures’? A framework has value but will be nothing more than rattling, dry bones, unless we create spaces to share real stories about these real issues.

A REAL STORY FROM 2 SOURCES – When cultures collide, who is caught in the middle?

“TICKLES” – 2 stories, 2 cultures, 2 toddlers, mixed sexual messages (by Ruth Loubser – told in tweets)

1st Story: Sr. Ruth with African parents of toddlers
Ruth talks to preschool parents at a large motororing company, 'Western Message': 'Don’t touch private parts unless necessary'. African mother – She still ‘tickles’ her son (he is 5). Her grandmother ‘checked her out’ until puberty! Other parents agree that it is normal to ‘touch’ in a playful way. Ruth acknowledges ‘cultural diversity’. Question: ‘How does the child know when they are being sexually abused?’ No clear answer about this. (More stories, more to learn.)

**LESSONS FROM THIS STORY**

1. **SAFE SPACES**: We need to create a supportive environment in which parents can verbalise their fears and concerns about sexuality. Lara’s history of childhood sexual molestation further complicated and confused this situation.

2. **PROACTIVE COMMUNICATION**: We must not avoid these teachable moments! As professionals we need to use them to model sexual communication clearly.

3. **SEXUALITY IS “EMBEDDED” IN OUR CULTURAL STORIES**: We tend to accept our own views or opinions as self-evident ‘common-sense’ without taking the effort to critique our often rigidly held sexual presumptions. These are ‘cultural’ stories. We must allow cultural dialogue, and openly acknowledge that our messages are from a particular perspective but then enable sexual communication within the family.

_E-mail subject line:_ SENSITIVE

**FACTORS THAT INHIBIT EARLY SEXUAL EDUCATION**

**FEAR**: Parents are afraid to speak to their children about sex and reproductive body parts and will often avoid the subject, or ‘wait for the child to ask a question’.

**SHAME/GUILT**: Religious and/or family repression and silences about sexual matters may have made the subject shameful or taboo in some contexts.

2. I am indebted to writings and conversations with Mmatshilo Motei (author of _The Kanga and the Kangaroo Court_ – Reflections on the rape trial of Jacob Zuma). She notes that indigenous African Tradition celebrated sexuality and taught clearly about this in various ways. We agree that much of this lost wisdom needs to be recovered but also needs to be critiqued.

**ENVIRONMENTAL FACTORS**

These include an eroticised environment and high levels of sexual abuse/rape within our country. The ‘gut instinct’ is to ‘shut the lid on tighter’! Pre-schoolers watch about 30 hrs of TV per week – more than any activity except sleeping.

**PARENTS WHO ARE SURVIVORS OF CSA (childhood sexual abuse)**

High statistics of childhood sexual abuse mean that many parents are survivors themselves. This increases anxiety around the subject and can even trigger personal sexual trauma related problems. See resource section for my pamphlet on this topic.

**EARLY SEXUAL MILESTONES**

Sexual development begins with the foundational needs of the child for care, comfort, affection and nurture given in a safe and trusting environment. These are the building blocks for later intimacy and communication within relationships. If these are absent or abusive, the child’s ‘sexual journey’ is off to a wobbly start!

AGE 2 – 4: Sexual curiosity begins and first ‘mutual body exploration’ activities are common. These include kissing, affectionate hugging or fondling and children are not aware of personal boundaries. These are socially constructed and need to be taught according to the cultural norms.

AGE 4 – 6: Usually by this age, the child will have inquired about their origins. If given simple factual information, the curiosity is satisfied. Parents who dodge this question set themselves up for problems in explaining basics of reproduction and preparation for

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Continued on page 16
and 8 perpetuates a culture of guilt and shame. This will compromise the journey of sexual and spiritual integration and hinder the development of values and where punitive can cause hyper-anxiety in early adolescence. Parents need to know that this behaviour is common for both genders and the child must be taught clearly about ‘public’ and ‘private’ spaces where these behaviours are permissible.

**KEY MESSAGE FOR PARENTS ABOUT MASTURBATION**

When adults react anxiously or in anger at innocent, natural exploration this can have lasting negative consequences for your child and perpetuates a culture of guilt and shame. This will compromise the journey of sexual and spiritual integration and hinder the necessary communication around this subject in relationships.

6 **Personal conversation with a general practitioner in private practice.**

7 **NUDITY AT HOME:** Families will have different norms about nudity in the home. They need to be open to what their child is feeling and honour a child’s verbal or non-verbal cues for privacy. Rules for when friends come to play need to be clear, and generally private spaces are the bedroom/bathroom.

WHERE DID I COME FROM AND ‘NAMING’ BODY PARTS: Early naming of sexual body parts is critical for helping a child to know, own and protect their body. This nurtures the body awareness, honours body integrity and helps the child to find their voice in other areas as well.

**THE PAEDIATRIC PRIVATE PRACTICE (Creating a supportive sexual education environment)**

Parents usually ‘parent’ in the same way they were – if early sex education was not ‘modelled’ for them, it will be difficult for them too. A supportive environment and spontaneous conversations can show parents how to introduce simple words or phrases to start them on this journey. Shifting our sexual lens from the ‘genitals’ to the ‘whole person’ allows us to step back and look for proactive ways to support the sexual development and education of the family.

THE PEOPLE: The paediatrician is a primary role-model and often the first place where the child experiences someone directly ‘in power over’ their embodied self. They can be a positive source of sexuality information for the entire family. Support staff in the practice can help reinforce key messages and allow the child to be heard. Where cultural complexities are under discussion, it is better to use a first language speaker and translator to achieve clarity and understand fully the dynamics of a situation.

CASE STUDY: A 5 year old black boy was circumcised and developed minor complications. A private practitioner treated him successfully. After complete physical healing, he was worried that his penis was now smaller than his peers. Months later he still has immense personal anxiety about this.

**THE POLICY:** When your parents first come into the practice, they can be informed of your holistic approach to wellness and supportive parenting. All aspects of health will be addressed including diet, sleep, age-appropriate stimulation and body awareness education (including sexual and reproductive health).

STATEMENT EXAMPLE: “Due to the potential harm/challenges associated with sexual ignorance, special effort is made to help parents understand early childhood sexual development and, where appropriate, share key messages that children need to hear. Parents can then reinforce these messages at home.” This policy empowers parents to fulfil their obligations in terms of the Children’s Act as I have articulated below:

**PARENTAL RESPONSIBILITY – Children’s Act 38 of 2005 (As amended by Children's Amendment Act 41 of 2007)**

Some parents feel that they are acting morally by withholding sexual information from their children. They confuse ‘ignorance’ and ‘innocence’. There is a legal obligation, in terms of the Children’s Act:

(General Principles – Chapter 2), for parents and caregivers to provide information on health care. This includes providing sexual health information in sufficient detail to promote health and prevent and/or treat disease.

Information on health care (1) Every child has the right to– (a) have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction.

Quote from Sr. Ruth’s open letter to caregivers – Stop HPV!

**NON-VERBAL COMMUNICATION (The physical environment)**

The majority of communication takes place through body language, tone of voice and other non-verbal cues. Creative ideas can be utilised to make the practice a welcoming space where the child is both ‘seen and heard’.

1. Consultation spaces

Traditionally, the doctor sits behind ‘the desk’ when the patient interview begins. This creates a physical barrier between the parent, patient and the practitioner. Circular, inclusive spaces will allow eye-contact and create an environment where the child can become a co-communicator and (as they get older) decision-maker in their health and well-being.

2. Signs and pictures

Pictures and signs can clearly mark ‘public’ and ‘private’ spaces. They can indicate where clothing could be requested to be removed e.g. in an examination room. Key messages can be printed below the picture, which would reinforce the message as children learn to read e.g. “We keep our clothes on in public spaces. This is a private space. You may be asked to take some of your clothes off for a check-up.” Explain to parents that they need to help their child to identify ‘public’
and 'private' spaces at home and the wider environment. The idea of 'private' body parts is then an extension of this learning.

Pictures or diagrams help a child to visualise internal organs – use them frequently! These are helpful from a very young age, and correct names should be given. Then when sexual body parts are ‘named’, they are not ‘out of place’, but an extension of holistic body awareness.

VERBAL COMMUNICATION (Modelling simple sexual messages for care-givers)

Acknowledge anxiety about this subject and emphasise the need for clear key messages about sexual body parts from an early age. Many parents still believe that sexual information will cause children to 'act out' sexually. This is a misperception and needs to be corrected early.

1. Handling a child’s resistance to intervention

A child’s instinctive reaction to protect themselves from someone ‘invading’ their body space is usually ‘over-ridden’ in the ‘best interests’ of treating the child for the illness with which they presented. This can send a powerful message that ‘I do not own my body’, ‘I am not allowed to protect myself’ or ‘I must allow an adult to do whatever they want to my body’. These are dangerous messages!

2. Permission to examine the body

A child’s feelings of resistance need to be validated and when the crisis is over, the child must receive explanations and give permissions for examinations etc. This honours the dignity of the child as a person, builds resilience and assertiveness.

Example: “You told me you have a cough and it will help for me to listen to your lungs. I can hear better when your shirt is off. May I do this now, please? Can you take off your shirt by yourself?”

When examining the genitals, you can include the key message, that “only a doctor or trusted adult should look at/touch the private parts”. In Western culture, after potty training, the genitals are only inspected if there is a problem. NOTE: The cultural story – this is not consistently so, and care needs to be taken to determine what message is appropriate for a particular child.

3. Learning sexual body parts

Use spontaneous teachable moments to include conversations where sexual body parts are named. This will model this difficult task for the parents. They can reinforce the messages at home.

On a chart or picture: “Do you know what this part of the body is called?”

Going to the toilet: “Wipe from front to back...”

Spontaneous erections: “Sometimes your penis is hard, and sometimes it is soft. This is called an erection. These are private conversations. We can talk about these body parts at home with your parents or here. We are teaching you to be healthy.”

Pregnant parent: This is an opportunity to show a model or picture to a young child to see where the baby is growing. Explore feelings about the new sibling.

4. Providing options where possible

This allows the child to start participating and making simple choices where appropriate. Case in point: Insertion of an anal suppository is an act of sexual penetration. Clear instructions about how medicines are given need to be provided. If there is an alternative means of administration, and the situation is not life-threatening, it is my opinion that the child should have a choice in this matter.

5. Structured conversations

Structured conversations are specific conversations with a child about a specific topic e.g. puberty, pregnancy, HIV etc. Usually these will happen at home. You can suggest some resources for parents e.g. books, websites or pamphlets with key messages.

6. Gender messages

Socialisation processes that reinforce prevailing gender stereotypes need to be critiqued. In my experience pre-teen and teenage girls have very poor body esteem that is further compounded through rampant exposure to glamour media and ‘nip and tuck’ ideals (especially if mother is doing it). In early childhood, messages like ‘You look beautiful today!’ or ‘Come on up here, big boy!’ become problematic when the girl no longer feels ‘beautiful’ or the boy is expected to feel ‘big and strong’ at all costs.

CONTROVERSIAL SEXUAL ISSUES

Childhood Transgender Identity – How early should a child be allowed to take on their trans-identity, and how does one navigate the trans-teen/trans-adult period best? Feelings of a trans girl approaching puberty (quoted in Hock), “I feel like I am getting empty. I’m going into a dark hole...and my life is going to end. I’m in the wrong place.”

10 Hock Pg 393

11 Hock Pg 383

Intersexuality: Practice and politics - Should routine surgical alteration of intersex babies be done? Is it ethical just because society cannot accept someone who does not conform to dimorphic norms? Is it wise before gender identity is established?

CONCLUSION

We are sexual beings from womb to tomb and collectively we are responsible for shaping the society in which we live. The ‘tickles’ story highlights socio-cultural complexities and the need for inter-cultural dialogue, followed by contextually relevant sexuality education at all ages. This requires an intentional shift in our focus and a willingness to be open to new ideas. The Body Ubuntu philosophy of sexuality, underpinned by values of dignity and care, emphasise the need to help children ‘know, own and protect’ their bodies. This attitudinal shift visualises the child as a person with a fundamental right to ‘body integrity’ and the potential to develop skills to safeguard this. In the current sexual climate, there is an urgent need to enable sexual resilience as early as possible.

Private paediatricians have tremendous influence in the lives of new families. Through simple and creative ideas, they can both empower the child and play a significant role normalising early childhood sexual education for fearful parents. And when the child becomes a competent, assertive communicator in later relationships, s/he can
proudly say, ‘My doctor helped me, when I was little!’

REFERENCES


RESOURCES

Websites and resources:

Sr. Ruth Loubser: www.sisterruth.co.za

Genesis Community Brochure – Breaking Silence

SUMMARY OF HEALTH NEWS: SEPTEMBER 2012

A summary on CMS’s financial report: CMS summary, issued in September

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

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

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

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

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

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

However, these suggestions will be worth less than the paper they were written on if the DoH does not effectively implement an ethical code of conduct. The transformation of SA’s malfunctioning, chaotic public healthcare, as well as problems in the private healthcare sector, will not be possible if it is not founded on an ethical code that does not tolerate corruption, fraud, poor performance, lack of productivity and bad management. (Zero tolerance has become a meaningless buzz word, but maybe that is what we need.)
The Medical Research Council (MRC) is the custodian of all medical research in SA. It funds 27 in-house research units and 23 in hospitals and universities. Government allocated R246m in 2012; 43% (R67m) is spent on in-house research and 19% on university-based research. However, the funding is not nearly enough as one drug study on malaria, for example, costs R15m.

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

Source: Troye Lund: The Financial Mail, 7 September; The Times, 31 August 2012

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

Source: Business Day, 10 September 2012

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

Source: Business Day, 12 September 2012

People who opposed the formation of the NHI in SA were “opposing something they don’t understand”, said Motsoaledi. Those who issued health tenders for things that had nothing to do with health were driven by “uncontrolled commercialism”. He also complained about the tendency in private hospitals towards a “medical arms race” where expensive, non-essential equipment was purchased and the price passed on to the consumer.

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

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

Source: Mail & Guardian, 14 September 2012

Longer stays in ICUs, the use of more expensive drugs when patients are admitted to hospitals, a dramatic increase in “in-hospital” pathology, and extended periods spent in hospital for procedures are some of the reasons private hospital costs have escalated way above consumer and medical inflation rates, said Discovery Health CE Jonathan Broomberg at the recently held HASA Conference. If hospitals could perform medical procedures in a shorter time, patients could pay a fraction of current hospitalisation fees. He showcased a pilot project run by Discovery in which it cut the number of days patients were hospitalised for hip replacement surgery from seven days to three-and-a-half days. This resulted in the total cost decreasing to R70 000 compared with the R110 000 charged by the private hospitals. He said high-volume surgeries should be created. New technologies, new facilities and doctors’ decisions in referring patients to hospitals were the supply drivers. This raised a question as to whether new hospitals being built were just another reason for increased utilisation, said Broomberg.

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

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

Source: Business Report, 25 September; The Times, 25 September 2012
HIV budgets come under pressure

International response to HIV is shrinking and commitments are uncertain because of the global economic crisis, donor fatigue and other factors. Governments have to take more fiscal responsibility for HIV. According to Treasury data, total spending on HIV was R16,9bn for 2010/11, of which R5bn was from donors.

- More recently economists have entered the ranks of the key HIV decision-makers, resulting in an increasing emphasis on investing strategically and directing resources where they will have the greatest impact and provide the best value for money. Preliminary results of the first SA national AIDS spending assessment show that the antiretroviral budget is dwarfing all other spending on HIV. About 10% of SA’s total spending on HIV was on prevention with several provinces spending less than 10% on prevention.

The large variations in spending suggest the provinces find it difficult to establish what the best strategies are, and spend a little on everything. It is harder to show that a properly run programme to change behaviour over 10 years can produce positive results because it is difficult to isolate the effect of the programme from all the other influences. Spending effectively on prevention is an investment. Spending now on effective prevention will save expensive, life-long treatment in the future.

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

Source: Mail & Guardian, 21 September 2012

Beating cancer at its own game

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

Source: Mail & Guardian, 28 September 2012

DOCTORS, NURSES, HOSPITALS & TRAINING

Skeletal health system sitting on cash pile

“About 100,000 patients die, waiting for life-saving treatment, several provinces are sitting on a staggering R800m earmarked for improving healthcare. The failure of five provinces - KwaZulu-Natal, Eastern Cape, Free State, Limpopo and Northern Cape - to spend on vital infrastructure and equipment not only disastrously affects basic healthcare but could hamper the introduction of a NHI scheme.”

Health Minister Motsoaledi revealed in parliament that the five provinces had underspent their allocations for the hospital revitalisation programme by almost R2bn: Eastern Cape - R191m; KwaZulu-Natal - R228m; Free State - R134m; Limpopo R89m and Northern Cape - R158m. He said the failure to spend was due to delays in the awarding of tenders, rolling-over of budgets from the previous financial year, poor performance by contractors, termination of contracts and court challenges.

Source: The Times, 7 September 2012

Many too poor to access free health services

A study by UCT’s Health Economics Unit on two SA communities, investigating the costs involved in accessing health services, found that on average TB patients had spent R100, and HIV-positive patients on antiretroviral treatment (ART) R81, on travel each month to access treatment, while pregnant women paid R321 to access obstetrics services during their pregnancy.

These direct costs exceeded 10% of total household expenditure in two-thirds of households using obstetric services, in one-third of households with a member receiving TB treatment and in 23% of households with a member on ART.

Source: Health-e News Service, 7 September 2012

Kwa-Zulu scientists ‘hold key’ to HIV

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

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

Source: Business Day, 27 September 2012
Gauteng health ‘pushing hospital upgrades’; Outcry over hospital closure; Hospital beds unused; Doctors work by cell phone light; Generators and new MEC are now switched on; Litigation looms in E Cape; Recovery plan for Gauteng health department; Drop in newborn deaths in Gauteng

- The Gauteng health department received a qualified audit opinion based on its revenue, irregular expenditure, leave entitlement and capped leave commitments. The department has since appointed a CFO, Ndoda Biyela, to ensure there were tighter financial controls, improved contracts management and that the departments complied with the Public Finance Management Act.

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

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

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

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

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

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

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

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

Source: SAPA, 6, 24 September; The Star, 11, 17 September; The Times, 11 September; Business Day, 6 September; Health-e News Service, 25 September; Citizen, 27 September 2012

MEDICAL AIDS

Bid for clarity on medical PMBS fails

The Supreme Court of Appeal denied the BHF and the municipal workers' medical scheme the right to appeal against the dismissal of their application for clarity over medical schemes' obligation to pay prescribed minimum benefit (PMB) claims at full cost. The court did not give reasons for its decision. The North Gauteng High Court was originally asked to clarify the meaning of a regulation under the Medical Schemes Act that says medical schemes must pay PMB claims in full. The CMS has interpreted the regulation to mean that claims for PMBS must be paid at the providers’ invoiced price.

Medical schemes supporting the BHF say this interpretation of the regulation gives providers a blank cheque to charge as much as they like for PMB services. In November 2011 the High Court dismissed the BHF’s application, saying it did not have legal standing to ask the court to clarify the PMB matter. The judge said schemes affected by the PMB regulation should have brought the application to the court. Dr Humphrey Zokuza, (MD of BHF), said the denial of the appeal was a barrier to getting clarity on the PMB regulation, and had implications for other organisations and their right to represent their members.

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

Source: Personal Finance, 22 September 2012
Fair-pricing forum for healthcare may be set up; Taking healthcare’s competition pulse; Healthcare competition inquiry ‘may not address cost problems’

- Health economist Nicola Theron has questioned whether the CC’s planned healthcare inquiry would address the problems facing SA’s health system. The CC is deciding on the scope of an inquiry it plans to hold into the healthcare sector, a move many industry players fear may be the first step towards the government regulating prices. At the HASA Conference Theron said Econex research showed 60% of the real increase in medical schemes’ expenditure on hospital fees was due to factors other than price, such as older, sicker patients, longer hospital stays and new technology.

This contradicts the CMS’s argument that medical schemes’ increasing hospital expenditure has been driven by the lack of competition in the hospital market. However the Competition Tribunal had given the go-ahead to hospital mergers opposed by the CC. It found no evidence that these mergers would have an adverse effect on prices, she said.

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

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

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

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

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

Regulator advises smaller medical schemes to merge

Rising medical costs have prompted the CMS to ask some medical schemes with deteriorating finances to consider an amalgamation. The National Independent Medical Aid Society is in negotiations to merge with Resolution Health. The health economist at Econex, Mariné Erasmus, said the deteriorating financial position of medical schemes had more to do with their risk profile as a result of regulatory changes, which instituted the open enrolment concept, preventing schemes from cherry-picking some members and rejecting others.

The CMS said 60% of open scheme beneficiaries were in schemes that did not meet the 25% minimum solvency requirement. Small schemes spend about 15% more on beneficiaries’ claims than larger schemes. This might be due to a worse profile of lives, as small schemes had an older average age.

Source: Business Report, 11 September 2012

Medical aid trustees ‘are coining it’

The highest-paid trustees highlighted in the CMS’s annual report were: Liberty Medical Scheme trustees an average of: R703 000 a year; Medshield Medical Scheme - R422 000; Spectramed - R380 000; Fedhealth Medical Scheme - R297 000 and Discovery Medical Scheme trustees - R257 000.

- Discovery Health Medical Scheme’s principal officer, Milton Streak, reacted: “The fee was appropriate considering the size and complexity of the business with an annual income of R35bn.”

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

Source: The Times, 5 September 2012
Bonitas still hopes to recover property losses

After a year under curatorship, Bonitas Medical Fund has recovered only a few of the millions its previous board of trustees spent on inappropriate property and other deals, according to a report by the outgoing curator of the scheme, Joseph Maluleke. Criminal investigations into the loss of some R60m of members’ money to fund a questionable property development (Clansthal) and other investments were ongoing.

The Gauteng South High Court lifted the curatorship and ruled that Bonitas was ready to be run by its newly-elected board of trustees. Maluleke recovered more than R11m for Bonitas by selling two properties the scheme owned. Bonitas is seeking to amalgamate with Pro Sano Medical Scheme, and was in negotiations with another scheme over a potential merger. Last year, Bonitas made a surplus of R158,8m.

Source: Personal Finance, 15 September 2012

Integration can cut costs

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

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

Source: SAPA, 27 September 2012

Discovery aims to limit health inflation; Market shaker; In fine fettle despite cost pressures

At the release of its financial results, Adrian Gore, CEO of Discovery Holdings, said Discovery was going to use its scale to create a balance in the spiralling cost of healthcare by negotiating with hospital groups and health service providers. Discovery Health experienced the lowest-in-industry lapse rate at 3,9%. Gore said the scheme had gained a significant share of young and healthy members, who were buying low-cost plans.

The Discovery Health medical scheme had a 4,5% increase in total members under management to 2,4m in the 12 months to June. Discovery Holdings grew its operating profit by 21% to R3,4bn in the year to June. Since listing in 1999 the share price has gained close to 700% to about R56. Discovery has increased its earnings by 21% in the financial year. The largest contributor to the group is Discovery Life, which accounts for 53% of operating profit, or R1,82bn.

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

• DHMS continued to attract new members, had a low lapse rate of 4%, and had a significantly younger age profile of 31,8 last year, compared with the industry average of 34,8.

Source: Business Day, 6, 14 September; The Financial Mail, 14 September 2012

Civil society wants health insurance rules altered

Civil society groups have appealed to the Ministers of Health and Finance to reconsider plans for regulating health insurance products, saying they do not go far enough to protect consumers. In March, the Treasury published draft regulations to the Long-Term Insurance and Short-Term Insurance Acts, seeking to draw a clear distinction between medical schemes and health insurance policies.

The regulations proposed scrapping most gap-cover products, but would allow health insurance for loss of income, travel, emergency travel, HIV/AIDS and frail care. The draft regulations, which were open for public comment for six weeks, elicited strong criticism from companies selling gap cover products.

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

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

Source: Business Day, 21 September 2012
Medical Schemes’ increase rates for 2013

Discovery - 10,9%; Profmed - 8,56%; Momentum Health - 7,9%; Medscheme Medical Scheme - 7,5%; Topmed - 9,47%; Compcare - 6,9%; Pharos - 10,8% and Fedhealth - 7,9%.

Source: Business Report, 21 September; Personal Finance, 1, 27 September 2012

Medical and dental professions in HPCSA tariff guidelines discussions

The SA Medical Association (SAMA), the SA Private Practitioners Forum (SAPPF) and the SA Dental Association (SADA) made their respective representations regarding tariff guidelines to the HPCSA following a decision by HPCSA to place on hold publication in the Government Gazette of its proposed tariff guidelines. “It may seem counterintuitive, but we do believe that proper and full consultation will yield a quicker and fairer result than the Medical and Dental Board trying to railroad through an ill-conceived and inappropriate and unfair benchmark tariff that will bring forth a spirited legal challenge,” said Dr Chris Archer, President of the SAPPF.

Dr Mark Sonderup, Acting Chairman of SAMA agreed that any benchmark tariff for doctors and dentists should be based on a fair and transparent process that incorporated important principles such as the actual cost of running a practice, tiered consultations, and an updated codes and procedure list.

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

Source: Business Day, 6 September 2012

Cheaper biologics on cards for SA as Roche wins tender

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

Source: Business Report, 10 September 2012

New twist in Cipla Medpro controversy; Cipla Medpro under investigation

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

Source: Business Day, 4 September; Fin24.com, 21 September 2012

New authority to foster ethical drugs marketing

The medical industry launched a Marketing Code Authority to ensure more ethical advertising and promotion of medicines, devices and laboratory tests. The authority will enforce a marketing code that spells out the do’s and don’ts for the industry, including stiff penalties for offenders.

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

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

Source: Business Day, 14 September 2012

Sizwe Medical Fund was placed under provisional curatorship after it emerged that its principal officer, who was managing R2bn, had not finished school and there were alleged financial irregularities in the scheme and fraud in the election of its trustees. Sizwe has 156 000 beneficiaries. It had a solvency ratio of 27% at the end of last year. Marshall Gobinca was appointed provisional curator of Sizwe.

Source: Business Day, 6 September 2012

PHARMACEUTICALS

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Source: Business Day, 6 September 2012
CONTROL ASTHMA
LIVE A FULL AND SUCCESSFUL LIFE

INTRODUCING
breathe free
A Cipla ASTHMA EDUCATION INITIATIVE

“The prevalence of asthma in South Africa across all ages is 8.1%”

At Cipla we have been at the forefront of lung disease management for over 30 years. We recognize the need for asthma education in South Africa and have therefore launched a campaign addressing this issue. The aim is to empower clinic sisters, pharmacists and doctors alike to educate asthma patients and to effectively manage the disease using the correct treatment regimens.

The Breathe Free campaign is a Cipla asthma education initiative that addresses the educational gaps identified in the Global Initiative for Asthma (GINA) & other major asthma treatment guidelines.

Extreme adventurer David Grier has run 1000’s of kilometres. He has asthma.

Breathe Free Clinics are currently operating:

visit www.breathefree.co.za for more information

Reference:

Cipla Medpro (Pty) Ltd. Reg. No. 1995/004/127/07. Rosien Heights, Pastor Street, Rosien Park, Bellville, 7530. Tel (021) 943 4390. Fax (021) 943 4699. E-mail: medicalservices@ciplamedpro.co.za Website: www.cipla.co.za
**State determined to regulate logistics fees drug makers pay to wholesalers**

The DoH has refused to bow to calls from pharmaceutical wholesalers for it to protect smaller players in the industry. The government is trying to regulate the logistics fees paid by pharmaceutical manufacturers to wholesalers and distributors to get their medicines to pharmacies and doctors. This is part of the government's broad push to control medicine prices and give consumers a better deal.

Wholesalers buy medicines from manufacturers and store them until they get orders. Distributors do not take on the risk of purchasing the medicines, and move them between manufacturer and retailer only after they have been ordered. One of the issues facing the wholesale industry is the extent to which the government's latest proposals will enable pharmaceutical companies to negotiate logistics fees below the caps set by the government. The DoH did not believe a minimum fee was appropriate, as it would be anti-competitive.

**Merger will take Litha to healthy heights; Litha Healthcare forges ahead to tap into new markets**

Litha Healthcare envisions its pharmaceuticals division becoming the fifth-largest generic medicines player in the local market after acquiring Pharmaplan for R590m. Litha's pharma division grew its turnover by 61% in the half-year to June. Earlier this year Litha and the DoH reached an agreement to run the Biovac facility as a joint venture. Litha's operating profit lost 12% because of lower sales in the medical unit, once-off costs relating to the Pharmaplan deal and costs of investment in the drugs unit.

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

**Aspen: Prescription for growth? Aspen’s earnings to rise 18%-24%; Aspen sets sights on overseas growth**

Aspen Pharmacare will focus on growing its Latin American and Asia Pacific businesses after reporting a 23% increase in revenue to R15,3bn from continuing operations increased. Operating profit was up 25% to R3,9bn.

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

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

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

**R1,6m payout taken to court**

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

Source: The Times, 7 September 2012

For a copy of the draft amendment click here http://www.info.gov.za/view/DownloadFileAction?id=174653

Source: Business Day, 25 September 2012
**Romney would keep parts of Obama healthcare law**

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

*Source: Reuters, 9 September 2012*

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**Reducing salt intake can prevent thousands of cardio-vascular deaths a year**

According to research published in the SA Medical Journal reducing salt intake can prevent 7 400 cardio-vascular disease deaths annually. Bread and margarine had the highest salt content. Soup powders and seasoning were the next highest. The World Health Organisation recommends a daily salt intake of 4g to 6g a day but the average South African consumes 8.1g. Salt content in food has to be decreased gradually to allow the taste buds to adapt.

*Source: The Cape Times, 18 September 2012*

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**China to expand insurance so sick don’t ‘lose everything’**

Health Minister Chen Zhu, a Paris-trained haematologist, announced that China will expand national health coverage by roping in private insurers and including more major diseases, as it seeks to close the mortality gap between rural and urban residents while trying to contain costs. China will train more doctors, revamp public hospitals and cut medicine prices to improve services and lower costs. Spending on healthcare in the country is forecast to almost triple to $1 trillion by 2020.

*Source: Bloomberg, 17 September 2012*

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**Killer bug investigated**

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

*Source: The Times, 26 September 2012*

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**Tape measures for smokers?**

Amendments to the Tobacco Products Control Act and the effect of compelling tobacco companies to use unbranded packaging were recently discussed in parliament. Objections by MPs included that there was no “rationale” for greater restrictions on smokers’ activities and that the intention seems punitive rather than aimed at improving South Africans’ health.

However, MP’s would be on firmer ground if they were to challenge the practicality of the proposed amendments - such as that smokers on a beach should be at least 50m away from other people, or 10m from a window or door when smoking outside. The suggested ban on branding is also controversial as there is scope for unintended consequences, that will leave producers with little option but to compete on price rather than quality, and that lower prices might actually encourage existing smokers to smoke more.

*Source: Business Day, 21 September 2012*

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**ADDENDUM:**

**Financial Mail Cover Story The House That Gore Built**

**The right prescription**

Twenty years ago Adrian Gore and Barry Swartzberg, (both actuaries) left Liberty Life to form Discovery Holdings. “Medical aid was not a happy industry at the time,” says Gore. In 1992 Gore got backing for his plans from Rand Merchant Bank (RMB) and the bank became Discovery’s first client. Initially Discovery was forced to specialise in health as it could not compete with the core Momentum business. In 2000, when it launched its life business, it was prohibited from selling its savings and investment business: instead it had to focus on risk products such as death, disability and critical illness.

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

Discovery Life also marketed a new range of dread disease and disability products, among them occupational disability and dread disease (going beyond the list of 10 tightly defined conditions).
The Vitality programme provided a competitive edge for Discovery, as it was able to offer lower premiums and cash back after five years to clients with a high Vitality status.

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

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

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

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

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

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

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

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

**Growing abroad with Vitality**

When Discovery entered the US market in 2001, the prospects looked encouraging. Like Discovery medical aid in SA, its Chicago-based subsidiary Destiny covered almost everything. But Destiny is, to date, Discovery's only significant failure. Gore says lessons learnt in the US were applied to subsequent international forays. "One was that we needed a blue-chip partner in each country: Prudential in the UK and Ping An in China, who approached us to partner them."

Acquiring Standard Life Healthcare (SLH) two years ago has put Discovery in a powerful position in the UK's relatively small private healthcare system. After the acquisition, the call centre business, which in PruHealth was run from Sandton, was consolidated into the Standard Life offices in Bournemouth.

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

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

PruProtect and PruHealth save costs as they can share common areas such as human resources, finance, compliance and actuarial functions. The common factor of the Vitality programme helps both businesses to grow. In the year to June 2012, the combined total premium for the businesses was R5bn. Discovery also agreed to take a stake and reshape China's Ping An Health into a business with all the familiar characteristics such as Vitality.

**Cow with plenty of milk**

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

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

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

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

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

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

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

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

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

**Staying alive is no joke**

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

For regulatory reasons Vitality is a separate business outside the Discovery Health Medical Scheme. It made just R5m
Paediatric Food Allergies Often Not Treated Properly

By Christine Kearney

American children with food allergies should be receiving better care, including diagnostic testing and attention to severe allergic reaction symptoms, according to a study conducted by researchers at Northwestern Medicine.

Ruchi Gupta, M.D., an associate professor of paediatrics at Northwestern University Feinberg School of Medicine, as well as a physician at the Ann & Robert H. Lurie Children’s Hospital of Chicago, explained:

“Every child with a food allergy should be diagnosed by a physician, have access to life-saving medication such as an epinephrine autoinjector and receive confirmation of the disease through diagnostic testing. Not all children are receiving this kind of care.”

The trial, which was published in the Journal of Allergy and Clinical Immunology, the official journal of the American Academy of Allergy, Asthma and Immunology, involved data from an online survey taken by US households with children suffering from symptoms indicating mild-to-severe food allergies.

The study is the first to provide information about how children’s food allergies are usually diagnosed and the treatment options they are given to manage their conditions.

The researchers concluded that 70% of the people who answered the survey reported that their child was diagnosed by a doctor regarding their food allergies. Of these children who were diagnosed by their physician, 32% never had diagnostic testing, including skin, oral food challenge tests or blood tests.

For those who were given diagnostic testing, skin tests were reported as most common, with 46% having received these tests. 39% reported to have received a blood test.

They also found that minority and lower income households had a higher chance of having children who had food allergies, but were not diagnosed.

A mere one out of five parents involved in the study said that their child took part in an oral food challenge test, which is the most efficient testing method for diagnosing food allergies.

To read the rest of the article click here - http://www.medicalnewstoday.com/articles/250236.php

Mums don’t notice toddlers’ weight gain

Others are increasingly failing to recognise signs of weight gain and obesity in their own children, a health researcher says.

Presenting at the International Congress of Dietetics, Queensland University of Technology researcher Rebecca Byrne stressed how prevalent weight underestimation is among today’s mums compared to previous generations.

Her research showed a mere four per cent of 276 surveyed mums recognised their toddlers were overweight, even though 32 per cent actually fit into that category.

She fears the weight they gain in infancy and childhood will be hard to budge later in life.

Source: www.paediatricsupdate.com.au
Researchers Improve Gene Therapy Technique For Children With A Form Of Severe Combined Immunodeficiency (SCID)

By including chemotherapy as a conditioning regimen prior to treatment, researchers have developed a refined gene therapy approach that safely and effectively restores the immune system of children with a form of severe combined immunodeficiency (SCID), according to a study published online recently in Blood, the Journal of the American Society of Hematology (ASH).

SCID is a group of rare and debilitating genetic disorders that affect the normal development of the immune system in newborns. Infants with SCID are prone to serious, life-threatening infections within the first few months of life and require extensive treatment for survival beyond infancy.

Adenosine deaminase (ADA) deficiency, which accounts for approximately 15 percent of all SCID cases, develops when a gene mutation prohibits the production of ADA, an enzyme that breaks down toxic molecules that can accumulate to harmful levels and kill lymphocytes, the specialized white blood cells that help make up the immune system. In its absence, infants with ADA-deficient SCID lack almost all immune defenses and their condition is almost always fatal within two years if left untreated.

Standard treatment for ADA-deficient SCID is a hematopoietic stem cell transplant (HSCT) from a sibling or related donor; however, finding a matched donor can be difficult and transplants can carry significant risks. An alternate treatment method, enzyme replacement therapy (ERT), involves regular injections of the ADA enzyme to maintain the immune system and can help restore immune function; however, the treatments are extremely expensive and painful for the young patients and the effects are often only temporary.

Given the limitations of HSCT and ERT, in the 1990s researchers began investigating the efficacy of gene therapy for ADA-deficient SCID. They discovered that they could “correct” the function of a mutated gene by adding a healthy copy into the cells of the body that help fight infectious diseases. Since then, there have been significant advances in gene therapy for SCID, yet successful gene therapy in patients with ADA-deficient SCID has been seen in only a small series of children due to the difficulty of introducing a healthy ADA gene into bone marrow stem cells and to engraft these cells back into the patients.

“Although the basic steps of gene therapy for patients with SCID have been known for a while, technical and clinical challenges still exist and we wanted to find an optimized gene therapy protocol to restore immunity for young children with ADA-deficient SCID,” said Fabio Candiotti, MD, one of the study’s senior authors, senior investigator in the Genetics and Molecular Biology Branch of the National Human Genome Research Institute at the National Institutes of Health, and chair of the ASH Scientific Committee on Immunology and Host Defense.

To read the rest of the article click here - http://www.medicalnewstoday.com/releases/250161.php

HMPV common pathogen among preemies with respiratory infections

By Evan J. Anderson

Respiratory syncytial virus dominated as a primary pathogen that caused lower respiratory infection in premature infants, but human metapneumovirus was not far behind, according to recent study results.

Evan J. Anderson, MD, previously of Northwestern University Feinberg School of Medicine, and colleagues reported on data from a study of 1,126 babies who had been hospitalized with lower respiratory tract infection and had been born with prematurity, chronic lung disease or cardiac disease.

According to Anderson and colleagues, respiratory syncytial virus (RSV) was the most commonly noted pathogen associated with respiratory disease. However, the researchers identified human metapneumovirus (HMPV) in 9% of these high-risk children, making HMPV the second most common pathogen associated with respiratory disease in this group of patients.

The researchers noted some common characteristics among children who were more prone to HMPV; specifically, that they were more likely to have chronic lung disease and to have been more prematurely born than other infants in the analysis. Also, babies who were exposed to children aged 6 to 12 years were more likely to have HMPV. The researchers also noted that the peak HMPV was later in the typical cold season than RSV.

“Efforts to develop immunoprophylactic or therapeutic strategies should be intensified for high-risk infants and young children because HMPV is the etiologic agent of a substantial proportion of lower respiratory tract infections requiring hospitalization in these children,” the researchers concluded.

Source: www.healio.com
Flo Kids Sinus Care

- The only nasal irrigation device specifically designed for children.
- Has extra minerals required in the nose
- Isotonic, gentle and non-stinging
- Adjustable soft silicone tip for comfort and fit

Children as young as pre-school age able to tolerate intranasal irrigation
- Compliance extremely high - 90%

Good adjunctive treatment option for Allergic Rhinitis
- Maximises the efficiency of nasal steroids