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For National Health Insurance (NHI) to be successful the quality of public healthcare must improve ‘tremendously’ and a stop must be put to the pricing of private health ‘which is running away with us’, health minister Dr Aaron Motsoaledi told the Healthcare in Africa meeting in Cape Town recently.

This has probably been the signature tune for Dr Motsoaledi in many of his keynote addresses to all and sundry this year. There is no doubting his ability to bring about change – on the 30 November 2012, he announced to the world that South Africa had negotiated and secured a deal to buy a key anti-retroviral drug at a world record lowest price ever, thus making this form of treatment affordable and hence available to an additional 2.5 million people in the next two years. Demographers have recently reported that life expectancy had shot up by six years to 60 over the past few years thanks to the aggressive stance on ARVs.

More recently – 4th December 2012 – Jonathan Shapiro aka Zapiro, whilst addressing the Cape Town Press Club bemoaned the fact that the current political situation in South Africa left him devoid of optimism, with the exception of certain individuals like Dr Aaron Motsoaledi, who were bringing about much needed change.

What is to be our viewpoint on this change – particularly as 2013 is fast approaching?

As stated previously in Paediatric News, our long-term financial success depends largely on our ability to withstand the forces that would bring about the financial ruin of private paediatric healthcare. As the PMG Exco, we have cautioned against many of the Specialist DSP Agreements, as it is our belief that such agreements would prove detrimental to the long-term financial wellbeing of the private sector. It is interesting to read one of the goals of Medscheme as laid out in their end-of-year newsletter:

- We will also establish a Medscheme Specialist Forum to co-ordinate greater consultation between Specialist Societies, General Practitioners and the Medical Schemes. Both Fedhealth and Bonitas have successfully implemented their Specialist Networks during 2012. These have created a foundation for future collaborative engagement.

Whilst this may sound admirable, the crux of successful collaboration lies in all parties being equally active in the dialogue. There is a two-way process that is involved – not a one-way handed down ruling that is deemed appropriate. This is an issue that the PMG Exco is constantly addressing.

On a practical level, the question about fee determination for 2013 is topical. With most schemes offering an increase of between 5-5.5% tariff increase, it makes for interesting reading to peruse the average increase in medical scheme contributions for 2013 – as reported by Personal Finance, 27 October 2012 - Open scheme rate hikes average around 9,01%, according to Alexander Forbes Healthcare.

Bonitas (9,9%), Bestmed (8,99%), Hosmed (7,2%), LA Health (9,9%), Liberty (11%), Makoti (4/99%), Medihelp (11,2%), Resolution Health (10,8%), Spectramed (9,4%), Fedhealth (7,9 %), Health (7,9%), Discovery Health (10,9%), Profmed (8,59%), Pharos (10,8%) and Topmed (9,47%).

Dr Aaron Motsoaledi has promised change and 2013 will not see him disappointing. For Paediatrics in the private sector to succeed, it is essential that all PMG members make informed, carefully thought out decisions regarding long-term financial agreements. What may appeal in the short-term – improved cash flows – may well jeopardise long-term prospects when the full prospect of NHI reveals itself.
A debate is due to be held this Wednesday the 23rd January on the issue of the HPCSA’s continuing insistence that it can set a commercial and reimbursement tariff for the private sector.

The HPCSA is mandated to establish an Ethical (Maximum) Tariff to adjudicate claims of overcharging but nothing else. We at SAPPF understand and accept that. However we do not support its claim to be able to establish a commercial benchmark for the profession or a reimbursement tariff for the funding industry. It does not have a legal mandate to do anything more than establish an ethical tariff to enable it to perform its task of protecting the public and guiding the profession.

The job of establishing billing and tariff guidelines for the commercial use by the profession is in our opinion best left to others.

Firstly;

The HPCSA lacks the capacity to create a new tariff or to maintain an existing one and has no experience associated with the development of codes and tariffs.

Secondly;

The 2006 NHRPL Tariff is unacceptable as a starting point:

1. It is an outdated reimbursement tariff
2. It is unscientific and does not take into consideration practice costs
3. The baseline reimbursement tariff has decayed by 300 percent over the past 40 years and therefore should not be used as an ad hoc starting point for a new tariff
4. It lacks many codes currently in use

SAPPF has supported the move to find an acceptable alternative to the defunct RPL but in the absence of any tangible development by the authorities has established an entity, SACHI which is based on international principles and the system in use in the USA. We believe that this organisation which is open to all private sector stakeholders, could become a statutory body capable of providing the expertise, independence and transparency to perform the necessary tasks of creating a new inclusive coding and tariff structure for the profession and funding industry. Were SACHI found to be acceptable to the industry at large SAPPF would relinquish all ownership claims to the SACHI entity.

Why is the HPCSA determined to press ahead with its plans?

Clearly it has little to do with its claim that overcharging has got out of control, we believe is grossly exaggerated. We are of the opinion that the DOH has persuaded the HPCSA to introduce this tariff in its attempt to regulate what it believes are unacceptable high prices in the private sector, an assumption SAPPF challenges and can show to be unfounded.

The DOH needs low prices in the private sector to enable the envisaged NHI to contract private sector services, without which services the NHI will not be able to provide universal access to healthcare for all South Africans. While SAPPF is an avid supporter of improving access to quality care it can only be achieved in an environment in which the private sector doctor is able to cover his costs and earn a reasonable income.

Concentrating on affordability at the expense of availability and quality would be a disaster in the making, and result in the failure of not only the private sector but the proposed NHI as well.

Chris Archer 21/01/2013
What is a normal body temperature?

A normal body temperature is 36.8°C – 37.3°C but this value changes depending on where the temperature is measured. A temperature measured in the ear or rectum or mouth will be up to a full one degree higher than a temperature measured under the arm. So the body temperature taken under the arm can vary between 35.8°C to 36.3°C. The temperature also varies according to the time of day with evening and night time temperatures being up to one degree higher than during the day. So a normal body temperature fits into a range rather than a specific single figure.

Range of normal body Temperatures:
- Armpit: 34.7 – 37.3°C
- Oral: 35.5 – 37.5°C
- Rectal: 36.6 – 38.0°C
- Ear: 35.8 – 38.0°C

What is a fever?

A fever is a measured body temperature higher than the normal range. A temperature higher than 38°C measured in the ear is a fever or higher than 37.3°C measured under the arm is a fever.

Why do we get a fever?

A fever is a normal reaction of a healthy immune system. The fever occurs when the immune system reacts to an infection. The infection is caused by a germ, either a bacteria or a virus and these germs can cause ear infections, chest infections, meningitis, gastroenteritis or any other infection in any other area of the body. When these germs cause infection the immune system sends white blood cells to the area of infection.

These white blood cells are the soldiers in our body and they start the processes of defending the body against the infection. The white blood cells cause a number of things to happen. One of these things is a fever. The white blood cells release chemicals into the bloodstream that travel to the brain and tell the brain to heat up the body. The temperature set point in the brain (hypothalamus) is changed from around 37°C to around 40.5°C.

The body then starts to heat up and as it does this we automatically do things to help. We start to shiver, this pushes up the temperature and we decrease blood supply to our hands and feet and extremities. This is why the hands and feet look blue and feel cold even though we have a fever. The body temperature will rise up to the point that has been set and then the fever break and that is when we start to sweat and feel better again. As long as the infection is active, the immune system will continually make the body temperature rise and fall in an attempt to kill the germs. This means that if the infecting virus causes an illness that lasts for 5 days, then the temperature will rise to a fever up and down for 5 days. A fever will always break, whether you give medication or not. The fever will break quicker if you have given medication.

Is a fever dangerous?

No a fever is not dangerous. It is true that a fever that rises to high levels very rapidly can cause a fever fit (Febrile convulsion). These fever fits occur in about 8% of children and if the child is completely healthy before the fit, the fit is not harmful at all. Children who have brain injuries or neurological problems will have fever fits more easily. Fever fits in healthy children do not cause brain damage and do not mean that the child will have more fits or epilepsy.

Fever do make children feel unwell and miserable. The child will breathe a little more quickly than usual, drink less than usual, eat less than usual and be less active than usual. Controlling the temperature will make the child feel better and the child will therefore handle the infection more easily.
It is important to look for other symptoms when your child has a fever.

**Symptoms to look out for with a fever:**
- Coughing and rapid breathing
- Vomiting
- Diarrhoea
- Skin Rashes
- Headache and stiff neck
- Travel to malaria areas
- Bites on the skin
- Pain anywhere

### Why do we control the fever?

We control a fever to make the child feel more comfortable and the child will then breathe less quickly, drink better and cope with the infection better. It is not necessary to control a fever unless it is above 38.5°C. The medication that we use does not bring down the fever it rather sets the fever point at a lower level. So the child will still get a fever but the fever will be less high than without medication. Remember that if the infection is going to last a few days then the fever will come and go for a few days even if you are giving medication for the fever. The fever is a normal immune system reaction and is not something to be feared. The fever should rather be the sign that makes you look carefully at your child for other symptoms. Look at the whole child and don't panic about the fever.

### How do we control a fever?

When a child is sick and has a fever it is easiest to respond to the child’s needs. If the child is cold and shivering then make them feel comfortable by dressing them warmly but if they are hot and sweaty then don’t dress them warmly. You do not want to dress the child to make them sweat it out. You also don’t want to plunge the child into cold baths or wrap them in cold wet towels. This practice may even push the temperature higher. It is ok to wipe their forehead with a damp cloth or to have a fan blowing cool air onto them or have the windows in the room open. Be sure not to make the child shiver.

Make sure your child drinks cool liquids because they lose more fluid by evaporation when they have a fever and the cool liquid will help to keep the fever down.

**Medication:**

Paracetamol is the most well known and safest medication for fever and pain and the two most frequently used brands are Panado and Calpol. The oral syrup is available in a concentration of 120 mg of Paracetamol, per 5 ml of liquid.

Paracetamol suppositories called Empaped are available in 125 mg and 250 mg strengths.

The suppositories and the syrup are equally effective and safe. Because they are the same type of medication do not give both together at the same dose.

The dose of Paracetamol is 15mg per kilogram per dose and this can be given every 4 hours. This means for example that an 8 kg child will get 5 ml of syrup every 4 hours.

Ibuprofen is also safe and effective for controlling fevers and this is available in a syrup at a concentration of 100 mg per 5 ml and the dose is 5 mg per kilogram every 8 hours. The common brands are Neurofen and Brufen.

This means for example that an 8 kg child will get 2 ml of syrup every 8 hours.

Mefenamic Acid (Ponstan) is also available to control the fever. This is available in a suspension at a concentration of 50mg /5 ml and the dose is 25mg/kg per day in divided doses. This means that an 8 kg child should get 5 ml 6 hourly. Ponstan suppositories (125 mg) are given to an 8 kg child 1 suppository 8 hourly.

Please be aware that Ibuprofen and Mefenamic acid belong to the same group of medication and this group can cause tummy upsets, ulcers and kidney problems if used frequently and if used in children with diarrhoea and vomiting who are possibly dehydrated.

### When do I go to the doctor?

- If your child is <6 months old and has a fever above 38.5°C
- If your child is any age with a fever > 38.5°C and:
  - The fever has been present for more than 48 hours
  - There are other symptoms as mentioned above
  - Your child is not drinking or sucking well

Ask for help when ever you are unsure about what to do.

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**Important to Remember**

- If you think there is a fever then measure the body temperature.
- Fevers are not harmful but are rather a normal reaction to an infection.
- Look at the whole child when a fever is present and take note of the other symptoms.
- Keep the child comfortable and make sure food fluid intake.
- Use Paracetamol, Ibuprofen and Mefenamic Acid at the recommended doses.

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This information provides a general overview on Fever 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.
New on the website:

You may have noticed that the website's public side has a new look and feel with stronger PMG branding. Under the Events section you will find a list of local and international conferences of Paediatric interest. The secure section has remained mainly unchanged.

New on the secure section is the Journal section. The following Journals are now available on the PMG website:

1. New England Journal of Medicine
2. Journal of Pediatric Infectious diseases
3. Paediatric Dermatology Journal

These Journals will soon be joined by the Archives of Diseases in Childhood & The Journal of Pediatrics. Due to the license type PMG has, the archives of these journals are not available.

Pead IQ

PMG has entered into an agreement with a commercial entity Paed-IQ Ltd. As part of the agreement PaedIQ will provide free prescription pads for PMG members starting in January 2013. Each member will be entitled to receive 10 Script pads of 100 pages per pad every quarter.

In addition, every PMG member will also receive a free personalised web address page which will list the member’s practice details. These personalised links will allow the public to locate Paediatricians in their area and offer access for parents and caregivers to the Paed-IQ platform. Paed-IQ has partnered with a major corporation allowing access to the site to over 3 Million South Africans. The potential synergy of this partnership ensures that PMG and its members are positioned at the forefront of Private Paediatric Practice in South Africa.

Participation in this project by members is voluntary and only those members who complete the forms will participate. The form is required to provide the necessary information on the script pads and web address, and to indicate your interest in this project. Paed IQ may contact you if they need to verify your details.

More details of the Paed IQ platform and services will follow in 2013.

STUDY IDENTIFIES INFANTS AT HIGHEST RISK OF DEATH FROM PERTUSSIS

You may have noticed that the website’s public side has a new look and feel with stronger PMG branding. Under the Events section you will find a list of local and international conferences of Paediatric interest. The secure section has remained mainly unchanged.

Early and Repeated White Blood Cell Counts Are a Critical Tool

A study released this week from the upcoming issue of the Journal of the Pediatric Infectious Diseases Society (JPIDS) found that taking early and repeated white blood cell counts (WBC) is critical in determining whether infants have pertussis and which of those children are at highest risk of death from the disease.

In 2010, California reported its highest pertussis rates in 60 years. Murray, et al’s retrospective study used medical records from five Southern California Pediatric Intensive Care Units between September 2009 and June 2011. Of the 31 infants studied, eight comprised a group considered to have more severe infections, which included suffering from pulmonary hypertension and death from the pertussis.

The study showed that infants who had more severe disease had higher WBC counts and were more likely to show at least a 50% increase in WBC. Infants with more severe disease had median peak WBC counts of 24,100 compared to 24,200 among infants with less severe disease. All but one of those with more severe disease had at least a 50% increase in WBC within 48 hours, and none of those infants with less severe disease had more than a 50% increase in WBC.

Additionally, the group of infants with more severe infections had higher maximum heart and respiratory rates and was more likely to develop pneumonia. All of these conditions occurred earlier after illness onset among infants with more severe disease. This group was more likely to have seizures, hypotension/shock, renal failure, and was more likely to be intubated and receive exchange transfusions. Six of the infants received exchange transfusions, and four of those died. Those four were all in shock at the time of their transfusions; the two who survived were not in shock at the time of transfusion.

Also known as whooping cough, pertussis is a highly contagious bacterial infection of the respiratory tract. Most children are vaccinated against pertussis at an early age, but infants are too young to complete the vaccination series. The U.S. Centers for Disease Control and Prevention reports that 2012 rates of the disease are at their highest level in 50 years and some states are reporting case counts not seen since the 1930s, which was prior to the vaccine era.

“Because very young infants have not yet been vaccinated and are at the highest risk for severe disease, we need to better manage and treat it,” said Erin Murray, lead author of the study and epidemiologist at the California Department of Public Health. “This study shows the importance of aggressive pediatric intensive care and provides us additional metrics as we treat these very young patients.”

Source: http://www.medicalnewstoday.com/releases/254960.php
Vitamin D Levels In Children Most Likely Determined By Supplements Taken And Consumption Of Cow’s Milk

Taking a vitamin D supplement and drinking cow’s milk are the two most important factors that determine how much vitamin D is in a child’s body, new research has found.

Those factors play a bigger role than even skin colour and exposure to the sun, according to Dr. Jonathon Maguire, a researcher and pediatrician at St. Michael’s Hospital.

“Early childhood is a critical stage in human development, so achieving and maintaining optimal vitamin D levels in early childhood may be important to health outcomes in later childhood and adulthood,” Dr. Maguire said.

His research was published in the Archives of Pediatrics and Adolescent Medicine.

Vitamin D deficiency is a risk factor for a number of illnesses, including asthma and allergies in children. Severe deficiency can cause rickets, a softening of bones.

Yet dietary records of Canadian infants show that at 12 months they are receiving only 11 per cent of their recommended daily allowance of vitamin D through food such as oily fish, fortified dairy products and cereals. The rest needs to be obtained through other means, such as supplements or when the skin is exposed to the sun’s ultraviolet rays. Lighter skin produces more vitamin D than darker skin colours.

Dr. Maguire studied vitamin D blood tests of 1,896 health children under 6 years of age. The children were part of TARGet Kids! (The Applied Research Group for Kids!), a unique collaboration between children’s doctors and researchers from St. Michael’s Hospital and The Hospital for Sick Children.

The program follows children from birth with the aim of preventing common nutrition problems in the early years and understanding their impact on health and disease later in life.

Researchers found the two factors most strongly associated with higher vitamin D stores in children under 6 years of age were taking a daily vitamin D supplement and drinking two cups of cows milk a day. Both of those factors were better at predicting a child’s vitamin D stores than skin colour or measures of exposure to the sun.

“When it comes to maintaining sufficient vitamin D stores in young children, the story is about dietary intake of vitamin D through vitamin D supplementation and cow’s milk,” said Dr. Maguire who was surprised to find that 57 per cent of the children were taking a regular vitamin D supplement.

He said this could be a result of parents hearing evidence about the benefits of such supplements through the media.

Research published by Dr. Maguire in the journal Pediatrics in December found that drinking two cups of cow’s milk per day was enough to maintain adequate vitamin D levels in most children. Drinking more cow’s milk could deplete iron stores in children’s bodies.

Source: http://www.medicalnewstoday.com/releases/254945.php

NORMAL IMAGING IN PATIENTS WITH CEREBRAL PALSY: WHAT DOES IT TELL US?

Objective

To identify distinctive clinical features characterizing children with cerebral palsy (CP) and normal-appearing magnetic resonance imaging (MRI) findings.

Study design

Using a population-based CP registry, the Registre de la Paralysie Cérébrale au Québec (Quebec Cerebral Palsy Registry), various antenatal, perinatal, and postnatal predictor variables, as well as current phenotype, were compared in patients with normal-appearing MRI findings and those with abnormal MRI findings.

Results

Of the 213 patients evaluated, 126 (60%) had MRI imaging results available and were included in our analysis. Of these 126 patients, 90 (71%; 51 males, 39 females) had abnormal findings and 36 (29%; 17 males and 19 females) had normal-appearing findings. Compared with other CP variants, normal-appearing MRI was more prevalent (P = .001) in dyskinetic CP (72.7%; 8 of 11) and less prevalent (P = .002) in spastic hemiplegic CP (10%; 4 of 40). There were no significant differences between the 2 groups (P > .05) in terms of the prevalence of perinatal or postnatal clinical features or clinical outcomes. Furthermore, 42% (15 of 36) of the children with normal-appearing MRI exhibited a high degree of functional disability (Gross Motor Functional Classification System IV-V), compared with 33% (30 of 90) with abnormal MRI.

Conclusion

No clinical features, except a higher prevalence of dyskinetic CP, was identified in the children with normal-appearing MRI. More refined imaging techniques may be needed to evaluate patients with normal-appearing MRI findings. Furthermore, genetic or functional, rather than gross structural lesions, may underlie the pathophysiology of CP in this cohort. Finally, the high proportion of substantial functional disability underscores the importance of continuous follow-up even in the absence of early structural abnormalities on imaging.

Source: http://www.jpeds.com/article/PIIS0022347612008694/abstract
Asthma is a serious condition that affects more than 25.7 million Americans, and is responsible for nearly 4,000 deaths annually. While the cause of asthma remains unknown, a study in the January issue of Annals of Allergy, Asthma and Immunology, the scientific journal of the American College of Allergy, Asthma and Immunology (ACAAI), has concluded that low birth weight is not associated with asthma risk in young children.

“Asthma is the most common chronic illness in childhood and is a leading reason for missed school days,” said allergist Hyeon Yang, M.D., lead study author. “While environment, genetics, and their interaction are thought to increase one’s risk of developing asthma, we now should not assume that low birth weight is associated with asthma. This is an important finding as we continue to understand who is at risk for asthma and why.”

Researchers examined a group of children born between January 1, 1976, and December 31, 1979, in Rochester, Minnesota. A total of 3,740 children in the study were born with normal birth weight and 193 children with low birth weight. Of the 193 children born at a low weight, only 13 (6.7 percent) developed asthma, and 201 of the 3,740 children born at a normal weight (5.4 percent) developed the disease.

The study concluded that birth weight did not have any association with a child developing asthma within the first six years of life.

“Asthma is a lifelong disease that is increasing every year within the United States, both by the number of people affected and by cost,” said allergist Richard Weber, MD, ACAAI president. “While researchers are still determining what exactly causes the disease, we do know how to effectively treat asthma in children and adults. It is important that those with symptoms see an allergist for proper diagnosis and treatment.”

According to the ACAAI, asthma can occur at any age but is more common in children than adults. In young children, boys are nearly twice as likely as girls to develop asthma. Although birth weight is not associated with asthma, obesity is a recently identified risk factor.

Asthma by the numbers:

- Asthma results in 456,000 hospitalizations and 1.75 million emergency room visits annually
- The estimated economic cost of asthma is $20.7 billion annually
- Asthma accounts for 10.5 million missed school days each year
- Patients with asthma reported 13.9 million visits to a doctor’s office and 1.4 million visits to hospital outpatient departments
- Improved asthma outcomes with allergists include:
  - 54 percent to 76 percent reduction in emergency room visits
  - 60 percent to 89 percent reduction in hospitalizations
  - 77 percent reduction in lost time from work or school

If you or your child has asthma, an Asthma Relief Self-Test is available here that is designed for you to review your asthma symptoms and help find relief.

Source: http://www.medicalnewstoday.com/releases/254941.php

As soon as the smoke-free laws came into force in England, there was a significant drop in asthma hospital admissions among children, researchers from Imperial College London reported in the journal Pediatrics.

According to National Health Service (NHS) statistics, within twelve months of the law banning smoking in enclosed places and workplaces, the number of children being admitted to hospital with asthma symptoms fell 12.3%.

The authors added that hospital admission rates due to asthma in pediatric patients continued to drop in subsequent years, demonstrating that the smoke-free legislation had and still has long-term benefits.

During the first 36 months, there were 6,802 fewer hospitalizations compared to the period before the new law came into force.

Approximately 1 in every 11 children in the United Kingdom has asthma, the researchers explained. Before the new legislation, the number of hospitalizations among children with severe asthma attacks had been growing by 2.2% annually. In the year 2006/2007, numbers peaked at 26,969.

As soon as the new law came into effect, the upward trend immediately reversed, for both boys and girls. The fall in figures was observed equally among children in well-off and poor neighbor-
hoods, as well as in cities and in the country. Other countries reported benefits from smoke-free laws.

According to previous studies, smoke-free legislation in Scotland and North America produced similar benefits for children with respiratory problems.

Researchers from Glasgow University reported that the smoke-free law introduced in Scotland in 2006 resulted in a drop in childhood asthma cases of 18% (average) annually. According to an article published in the NEJM (New England Journal of Medicine), asthma hospitalization rates had been increasing by 5.2% annually among children for over a decade and a half.

There was also a significant drop in the number of heart attacks in England after the new law came into effect.

Source: http://www.medicalnewstoday.com/articles/255190.php

Pretterm infants who grew more slowly as they approached what would have been their due dates also have slower development in an area of the brain called the cerebral cortex, report Canadian researchers in a new study published in Science Translational Medicine.

The cerebral cortex is a two to four millimetre layer of cells that envelopes the top part of the brain and is involved in cognitive, behavioural, and motor processes.

Researchers analyzed MRI brain scans of 95 preterm infants born eight to 16 weeks too early at BC Women’s Hospital & Health Centre between 2006 and 2009. Infants were scanned soon after birth and a second time close to what would have been their due date, the ninth month of pregnancy. These MRI scans allowed researchers to measure the pattern of water movement inside the brain, which normally changes between scans as the brain matures. The researchers also assessed the babies’ weight, length, and head size. They found that preterm infants with slower growth had delayed development in the cerebral cortex compared to those infants who grew more quickly between scans.

“These results are an exciting first step because understanding the importance of growth in relation to the brain in these small babies may eventually lead to new discoveries that will help us optimize their brain development,” says Dr. Steven Miller, the study’s co-lead. Dr. Miller is head of neurology at The Hospital for Sick Children (SickKids), the Bloorview Children’s Hospital Chair in Paediatric Neuroscience, professor in the department of Paediatrics at the University of Toronto, affiliate professor in the department of Pediatrics at the University of British Columbia (UBC), and affiliate investigator at the Child & Family Research Institute (CFRI) at BC Children’s Hospital. He led the study with Dr. Ruth Grunau, a professor in the UBC Department of Pediatrics and CFRI senior scientist.

“More research needs to be done to understand what is the optimal growth rate for the brain development of these babies,” says Jillian Vinall, the study’s first author and a UBC PhD student co-supervised by Dr. Grunau and Dr. Miller.

“We’re especially grateful to the families for their generous and ongoing participation in this study,” says Dr. Miller. The researchers are following the babies through childhood to understand how preterm brain development is associated with their neurodevelopment outcomes.

Source: http://www.medicalnewstoday.com/releases/255049.php

A newly developed community-based psychosocial and mental health care package for children affected by armed conflict has made effective care accessible to over 96,000 children, according to international researchers reporting in this week’s PLOS Medicine. Their article is part of the journal’s ongoing series on Global Mental Health Practice.

The authors led by Mark Jordans from HealthNet TPO and the Center for Global Mental Health at the London School of Hygiene & Tropical Medicine explain that the Program (called the Child Thematic Program) started in Burundi, Sudan, Sri Lanka, and Indonesia in 2004 and in Nepal in 2006. From the start, the care package was based on a public health model to include prevention, treatment, and rehabilitation interventions.

The article describes the way research contributed to the development of the care package. According to the authors, routine monitoring and evaluation combined with rigorous research design allowed for improvement and fine-tuning of services in real-life settings, and highlighted key gaps in current knowledge.

Source: http://www.medicalnewstoday.com/articles/255190.php

96,000 CHILDREN AFFECTED BY ARMED CONFLICT BENEFIT FROM A COMPREHENSIVE MENTAL HEALTH PROGRAM

Continued on page 12
Abstract

Background

Non-Hodgkin's Lymphomas (NHL) are common in African children, with endemic Burkitt's lymphoma (BL) being the most common subtype. While the role of Epstein-Barr Virus (EBV) in endemic BL is known, no data are available about clinical presentations of NHL subtypes and their relationship to Human Immunodeficiency Virus (HIV) infection and Epstein Barr Virus (EBV) load in peripheral blood of children in north-western, Tanzania.

Methods

A matched case control study of NHL subtypes was performed in children under 15 years of age and their respective controls admitted to Bugando Medical Centre, Sengerema and Shirati district designated hospitals in north-western, Tanzania, between September 2010 and April 2011. Peripheral blood samples were collected on Whatman 903 filter papers and EBV DNA levels were estimated by multiplex real-time PCR. Clinical and laboratory data were collected using a structured data collection tool and analysed using chi-square, Fisher and Wilcoxon rank sum tests where appropriate. The association between NHL and detection of EBV in peripheral blood was assessed using conditional logistic regression model and presented as odds ratios (OR) and 95% confidence intervals (CI).

Results

A total of 35 NHL cases and 70 controls matched for age and sex were enrolled. Of NHLs, 32 had BL with equal distribution between jaw and abdominal tumour, 2 had large B cell lymphoma (DLBCL) and 1 had NHL-not otherwise specified (NHL-NOS). Central nervous system (CNS) presentation occurred only in 1 BL patient; 19 NHLs had stage I and II of disease. Only 1 NHL was found to be HIV-seropositive. Twenty-one of 35 (60%) NHL and 21 of 70 (30%) controls had detectable EBV in peripheral blood (OR = 4.77, 95% CI 1.71 – 13.33, p = 0.003). In addition, levels of EBV in blood were significantly higher in NHL cases than in controls (p = 0.024).

Conclusions

BL is the most common childhood NHL subtype in north-western Tanzania. NHLs are not associated with HIV infection, but are strongly associated with EBV load in peripheral blood. The findings suggest that high levels of EBV in blood might have diagnostic and prognostic relevance in African children.

Source: http://www.biomedcentral.com/1471-2431/13/4

The authors say: “The program has resulted in improved case detection with a developed and validated screening instrument, making care accessible to over 96,000 children, and generating empirical evidence on the effectiveness of interventions.”

They continue; “Future development requires broadening the scope of the care package, that is, integration of treatment for severe mental disorders, stronger involvement of families, and strengthening of primary prevention approaches, and continued evaluation of new elements.

The authors conclude: “While we promote the current emphasis on accountability and the need to demonstrate the effect of interventions in humanitarian settings, we advocate a broader research agenda that also focuses on care/health system variables, as well as implementation and intervention mechanisms.”

Source: http://www.medicalnewstoday.com/releases/255128.php
Type D personality is a risk factor for psychosomatic symptoms and musculoskeletal pain among adolescents: a cross-sectional study of a large population-based cohort of Swedish adolescents

Abstract

Background

Type D personality, or the “distressed personality”, is a psychosocial factor associated with negative health outcomes, although its impact in younger populations is unclear. The purpose of this study was to investigate the prevalence of Type D personality and the associations between Type D personality and psychosomatic symptoms and musculoskeletal pain among adolescents.

Methods

A population-based, self-reported cross-sectional study conducted in Vastmanland, Sweden with a cohort of 5012 students in the age between 15–18 years old. The participants completed the anonymous questionnaire Survey of Adolescent Life in Vastmanland 2008 during class hour. Psychosomatic symptoms and musculoskeletal pain were measured through index measuring the presence of symptoms and how common they were. DS14 and its two component subscales of negative affectivity (NA) and social inhibition (SI) were measured as well.

Results

There was a difference depending on sex, where 10.4% among boys and 14.6% among girls (p = < 0.001) were defined as Type D personality. Boys and girls with a Type D personality had an approximately 2-fold increased odds of musculoskeletal pain and a 5-fold increased odds of psychosomatic symptoms. The subscale NA explained most of the relationship between Type D personality and psychosomatic symptoms and musculoskeletal pain. No interaction effect of NA and SI was found.

Conclusions

There was a strong association between Type D personality and both psychosomatic symptoms and musculoskeletal pain where adolescent with a type D personality reported more symptoms. The present study contributes to the mapping of the influence of Type D on psychosomatic symptoms and musculoskeletal pain among adolescents

Source: http://www.biomedcentral.com/1471-2431/13/11/abstract

Growth in VLBW infants fed predominantly fortified maternal and donor human milk diets: a retrospective cohort study

Abstract

Background

To determine the effect of human milk, maternal and donor, on in-hospital growth of very low birthweight (VLBW) infants. We performed a retrospective cohort study comparing in-hospital growth in VLBW infants by proportion of human milk diet, including subgroup analysis by maternal or donor milk type. Primary outcome was change in weight z-score from birth to hospital discharge.

Methods

Retrospective cohort study.

Results

171 infants with median gestational age 27 weeks (IQR 25.4, 28.9) and median birthweight 899 g (IQR 724, 1064) were included. 97% of infants received human milk, 51% received > 75% of all enteral intake as human milk. 16% of infants were small-for-gestational age (SGA, < 10th percentile) at birth, and 34% of infants were SGA at discharge. Infants fed >75% human milk had a greater negative change in weight z-score from birth to discharge compared to infants receiving < 75% (~0.6 vs. -0.4, p = 0.03). Protein and caloric supplementation beyond standard human milk fortifier was related to human milk intake (p = 0.04). Among infants receiving > 75% human milk, there was no significant difference in change in weight z-score by milk type (donor −0.84, maternal −0.56, mixed −0.45, p = 0.54). Infants receiving >75% donor milk had higher rates of SGA status at discharge than those fed maternal or mixed milk (56% vs. 35% (maternal), 21% (mixed), p = 0.08).

Conclusions

VLBW infants can grow appropriately when fed predominantly fortified human milk. However, VLBW infants fed >75% human milk are at greater risk of poor growth than those fed less human milk. This risk may be highest in those fed predominantly donor human milk.

Source: http://www.biomedcentral.com/1471-2431/12/124
FUNDING NHI

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

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

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

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

PRIVATE COOPERATION IN IMPLEMENTING NHI

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

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

BHP Billiton has donated R200-m to fund early childhood health projects in SA and Mozambique by international health organisation PATH. The project is expected to help at least 750 000 children and pregnant women in Gauteng, KwaZulu-Natal, Mpumalanga, the Northern Cape and Maputo.

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

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

Doctors: The SA Medical Association (SAMA) believed doctor shortages to be “one of the major issues” standing in the way of NHI. The number of graduates (1 200) produced each year by 8 medical schools would need to be doubled for the next 10 years for the country to have enough doctors. In addition, Government would have to introduce incentives to retain highly skilled medical practitioners and speed up the registration of foreign doctors seeking employment in SA.

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

Five important areas in the public sector according to Min. Motsoaledi: Infrastructure, human resources, quality of health

LEGISLATION, PLANS AND PROBLEMS

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

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

care, re-engineering the public healthcare system (deployment of retired nurses, school health programmes); and deployment of teams of specialists and nurses to the health districts, especially in rural areas.

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

**GENERAL NEWS**

**Vaccination:** The DoH has acknowledged it did not know how many babies were unvaccinated because it had only a hazy idea of the size of the population it was targeting. According to department figures there was a 95.1% coverage rate, however the figure from World Health Organisation (WHO) and United Nations Children’s Fund (Unicef), was only 72%.

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

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

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

**COMMENTS ON NHI**

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

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

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

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

Prof Gavin Mooney (CEO of Africa at Work, a consulting company focusing on African business): “Start with one of the big teaching hospitals and bring that up to speed in terms of quality of care, efficient management and management systems to act as a major demonstration project showing just what the public sector is capable of.”

Medical Chronicle survey: According to a survey the majority of SA’s doctors believe the country’s healthcare system does not have a bright future, but many are willing to help improve it. Most practitioners (56%) who responded did not support Government’s concept of NHI. They feel strongly that the focus should be on fixing up state facilities that are largely ineffective. Only 12.4% agreed with the statement that SA health had a bright future. The majority indicated that they were likely to stay in the country. Medical schemes were seen in a negative light by practitioners, who indicated that they were unconvinced that the schemes had members’ interests at heart.
In January 2011 Astellas Pharma initiated a campaign linked to their Dermatology portfolio. The campaign was set to run until the end of April 2012 and the objective was to increase awareness of rhino poaching, affirm awareness of the Astellas Dermatology products (Protopic®, Locoid®, SBR® Range) and in doing so, raise funds to assist in the fight against the illegal poaching of rhinos. RAGE was chosen as the NGO to receive these funds.

Evidence shows that there is a huge groundswell of public support for campaigns to protect the rhino, but many people are deterred from contributing either because they are unable to decide which of the many rhino-related organisations they should support, or because they are afraid that their donations may be diverted into the wrong hands.

RAGE (Rhino Action Group Effort) was set up by LeadSA (a Prime-dia Broadcasting and Independent Newspapers initiative) to assist in the fight against the illegal rhino poaching scourge. Specifically, RAGE was designed to be a safe conduit for public contributions to this cause, whether they be financial, material or in the form of skills and information.

A total of R22 250.00 has been donated to RAGE. R20 000.00 was raised from an element of the campaign whereby doctors could answer dermatology-related questions on a series of 5 cards. For every completed card returned to Astellas via their sales representative, an amount of R10.00 was donated to RAGE.

Since the beginning of 2012 South Africa has lost approximately 550 rhinos* to poaching – a shocking statistic.

A further R2 250.00 was raised during an activity held on the Astellas Dermatology exhibition stand at the ALLSA/PMG Congress in October last year. Customers who visited the stand could tie neck ribbons around handmade rhino soft toys and either purchase one for a cost of R50.00 each or donate the toy to charity.

The Avril Elizabeth Home and Cotlands were the recipients of the toys.

Established in 1968, the old convent in Fishers Hill, Germiston, is a warm and welcoming home to 147 permanent residents and provides day care to 23 intellectually disabled attendees of all ages, many of them with physical disabilities. Kate Meyer (Astellas Pharma) and Kathy Dover (KD Events & Exhibitions) visited Avril Elizabeth Home on the 21st of February 2012. The residents were delighted to see new faces and there was no mistaking that they were very appreciative of their Rhino’s.
For the treatment of **moderate to severe** atopic dermatitis in adults and in children (2 years of age and older)¹ as second line therapy¹

Non-steroidal treatment for rapid and sustained effectiveness²
- Favourable safety profile, does not interfere with collagen synthesis or cause skin atrophy²

Significantly more effective than pimecrolimus cream¹

¹ECT - Topical Calcineurin Inhibitor


Protopic® 0.1% Ointment (0.1 mg/g tacrolimus as tacrolimus monohydrate), 44013-12-0/15: Protopic® 0.3% Ointment (1.0 mg/g tacrolimus as tacrolimus monohydrate), 44013-12-0/23: For full prescribing information, refer to the package insert approved by the Medicines Regulatory Authority. Astellas Pharma (Pty) Ltd. Reg. No. 2001/02956/07. Girdles View Office Park, 5 Osborne Lane, Bedfordview. Tel 011 415 9451. Fax 011 415 9427. Protopic® Rev Aug 2011
On the 3rd of April this year Kate and Kathy visited Cotlands in Turfontein to hand over their rhino soft toys. Founded in 1936, this sanctuary for children and babies was born out of love by Matron Dorothy Reece. Their vision is to nurture the hero in every child. They provide an integrated model of care for young children and their families by empowering them and improving their quality of life.

Kate and the staff at Astellas Pharma would like to thank those who participated in this very worthwhile campaign.

The moneys donated to RAGE have been used in the funding of a research project to establish the best way to institute satellite tracking devices on rhinos.

If you would like additional information on the Astellas Dermatology Rhino Campaign, contact Kate Meyer: 011 615 9433 or kate.meyer@astellas.com

For more information about RAGE, please visit their website: http://www.rhinorage.org

* Source: RAGE
HIV/AIDS AND TUBERCULOSIS

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

Government’s HIV/AIDS programme: Pali Lehohla, Statistics SA’s statistician-general, said it looked as though SA had turned the corner, probably, in the face of availability of ARVs. However, it was hard to state that AIDS was the cause of the majority of deaths prior to 2006 because it was not a notifiable cause of death in SA.

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

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

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

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

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

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

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

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

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

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

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

UNAIDS’ latest statistics revealed that more than 2,5-m people worldwide were infected with the virus last year. Of the 34-m people living with HIV, about half did not know their HIV status. The number of children in the world infected with HIV decreased by 26% between 2009 and 2011.

Research and medication: In October Dr Glenda Gray, SA co-principal investigator for the HIV Vaccine Clinical Trials Network, said results of the RVI44 Rhai study in Thailand gave hope for a vaccine to prevent HIV infection. The vaccine had a 31% efficacy during trials. If the SA trial was successful, SA would be the first country where the vaccine would be licensed.

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

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

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

CANCER AND OTHER NON-COMMUNICABLE DISEASES

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

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

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

Five steps: could reduce deaths from cancer in SA, according to the Cancer Association’s head of research, Dr Carl Albrecht. They are: vaccinate all 10-year-old girls against human papilloma virus (HPV); gather accurate information on cancer prevalence, incidence and tendencies; modernise equipment; create a cancer council to co-ordinate cancer-fighting efforts; and use tax (R8-bn
SCRATCH NO MORE

The treatment of cutaneous disorders can be unnecessarily challenging (and often frustrating) for healthcare practitioners. Part of this has to do with the fact that a typical patient’s self-diagnosis is often highly subjective, the list of potential causes is seemingly endless, and the patient has frequently already applied a random OTC or homeopathic type of remedy to the skin - which may either be adding to the discomfort or else masking the symptoms.

Now, things are about to get a lot easier.

The introduction of two products – Atopiclair and Epi-Max® – means that simple and genuinely effective treatment is readily available for patients of all ages. Atopiclair, a non-steroidal cream for managing atopic dermatitis, is a one-stop solution to a problem which is becoming increasingly common, especially among younger children. This steroid-sparing antipruritic contains no topical corticosteroids and is suitable for use by adults as well as children over the age of six months – with all the benefits and none of the adverse effects of a typical steroidal cream. Impressively, the active ingredient in Atopiclair is Glycyrrhetinic Acid – a Licorice root extract that has demonstrated anti-inflammatory properties.

THE IDEAL VEHICLE BASE

Also formulated in response to frequent requests from dermatologists, Epi-Max®, the latest all-purpose emollient cream and general moisturiser, is not only an ideal companion to corticosteroidal creams, but also serves as a perfect vehicle for the delivery of a non-steroidal cream such as Atopiclair. The range of Epi-Max® products has been specifically designed to allow for use by adults, younger children, and even infants. Not only is Epi-Max® free of artificial colourants and fragrances, but this hypo-allergenic cream is completely water-soluble, which makes it ideal as a soap substitute for patients whose dermatitis may be triggered or exacerbated by commercial soaps.

PRESCRIBE OUR FAMILY FOR THEIR FAMILY – WITH CONFIDENCE

The most frequent response to Atopic Dermatitis is to prescribe topical corticosteroids, or topical calcineurin inhibitors. Along with phototherapy, antihistamines are also often prescribed. Unfortunately, the potential for adverse reactions and undesirable side effects is significant, with the result that many healthcare practitioners are (understandably) cautious when doing so. Now, using a combination of allied products – in this case, Atopiclair and Epi-Max® – allows practitioners to prescribe and dispense with absolute confidence. The active ingredients in Atopiclair are effective in addressing the underlying problems associated with AD (for example, by restoring epidermal barrier function), while Epi-Max® not only serves as a vehicle for delivery, but also acts as an occlusive barrier to any further irritation caused by infection or exposure. In addition to this, Epi-Max® is of course an excellent humectant in itself, which complements and supports the treatment.

A GENTLE & EFFECTIVE WAY FORWARD

Every advance in the treatment of Atopic Dermatitis is cause for celebration, and even more so when the task of health givers is simplified as a result. More effective results, and the reduction or elimination of adverse side effects, means happier doctors - and delighted patients.

This is the future of Atopic Dermatitis treatment, and a whole new range of possibilities has become a reality.
Turn a frown upside down

ATOPICLAIR is a non-steroidal cream for managing mild to moderate atopic dermatitis in adults and children over the age of 6 months.

Relieves, Restores, Protects!

AN ALL PURPOSE MOISTURISER THAT IS CARING ENOUGH FOR THE WHOLE FAMILY

Keep their family’s skin moisturised and protected throughout the year with Epi-max® all purpose moisturiser: a cost-effective solution for dry skin that is gentle and mild enough for the whole family.

Prescribe our family for their family

Hypo-allergenic | Free from artificial colourants & perfumes
Dermatologically tested | Not tested on animals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A FEW EXAMPLES

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

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

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

In September Gauteng’s head of health, Nomonde Xundu, admitted in parliament that many of the province’s revitalisation projects were behind schedule and over budget. She has since resigned.

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

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

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

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

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

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

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

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

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

Western Cape: One in five patients treated at some state hospitals in the Western Cape are from other provinces or countries, according to a report early in the year. DA Premier Helen Zille said the health system in the province was “functional and delivering quality care to patients” due to strong leadership, strict control and fiscal discipline.

According to Econex research the Western Cape’s doctor-to-population ratio was 135 doctors per 100 000 people - the healthiest ratio in South Africa. This is followed by Gauteng with 102 doctors per 100 000 people and the Free State with 55 per 100 000 people.

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

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

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

Economist Mike Schussler compiled statistics from independent sources such as Statistics SA, the National Treasury and the Council for Medical Schemes reports. According to Schussler almost 100% of the cost in private hospitals care is borne by the client, whereas only 2% of the cost of public hospitals’ care is charged to the client. Just because a public hospital client doesn’t pay 98% of the cost of their care doesn’t mean that this cost does not exist. Someone else (a taxpayer) has to do the paying, said Schussler.

As this payment was channelled via Government, instead of paid directly to the hospital, a significant portion was diverted into Government itself to cover administration and the like. In other words, Government funding figures will underestimate the actual cost of public hospitals to taxpayers. The declining public admission rate per capita proves that Government’s healthcare policy leads to less care for the poor according to Schussler.

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

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

DOCTORS, DENTISTS AND NURSES

Doctors: Universal healthcare coverage in SA is threatened by the rate of the brain drain among doctors, according to Econex director Cobus Venter. SA had enough financial capacity to sustain its doctors, while importing foreign doctors was costing the country more, he said. Doctors left because of uncertainty and poor working conditions and not because of financial reasons. Although universities have all increased their intake of students, it is not enough when considered that 50% of doctors leave the country within 5 years. Practitioners registered with HPCSA fell from 168 160 in 2011 to 165 371 in March 2012. Doctors in the private sector have agreed to contribute their skills (4 hours a day) to public health-care, and in particular to the NHI pilot programme.

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

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

TRAINING

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

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

Universities and teaching hospitals did not ensure adequate teaching facilities, according to the study. At three out of the seven institutions, registrars were exposed to less than three quarters of the surgical procedures required by the College of Medicine of SA. Prof Dan Ncayiyana, editor of the SA Medical Journal said the problem lay with the teaching hospitals. However, SA still produced the best specialists who were in demand all over the world. Earlier in the year Min Motsoaledi announced that academic hospitals will be controlled by the national department by next year.

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

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

Grants: Nursing colleges were promised a grant for R100-m from the National Nursing Colleges and Schools Grant, which totals R100-m for 2012-13.
CONSOLIDATION OF MEDICAL SCHEMES

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

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

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

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

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

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

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

NHI AND MEDICAL SCHEMES

Board of Healthcare Funders (BHF): In its submission to the government’s Green Paper on NHI, the BHF emphasised that the private healthcare sector’s expertise and sophisticated infrastructure could be utilised in the NHI. The private sector needed to reform in order to align with national health policy and ensure a seamless integration of the 8.5m medical scheme members into the NHI.

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

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

TARIFFS: HIGHER TARIFFS, LESS BENEFITS AND GUIDELINES

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

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

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

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

The Competition Commission’s inquiry into healthcare costs (announced in August) will consider what is driving costs, how the market has evolved since negotiations between schemes and providers over healthcare tariffs were stopped and the policies that could be adopted to address problems in the market.

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

The Competition Act in its current form does not provide for formal market inquiries, nor does it empower the CC to summon people to provide information. However, the Competition Amendment Act, passed by parliament but given no effective date, provides for market inquiries and gives the CC special powers to summon witnesses and to require individuals to give evidence under oath.

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

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

2013 tariffs: Some medical schemes have failed to implement the price recommendations of the CMS because healthcare costs tend to rise faster than the consumer price index (CPI). Some of the tariff increases for 2013 are: Discovery: 10,9%; Profmed: 8,56%; Momentum Health, 7,9%; Medshield Medical Scheme, 7,5%; Topmed: 9,47%; Compcare: 6,9%; Pharos: 10,8%; and Fedhealth:7,9%.

Claim costs: The average increase in claims costs per beneficiary continued to exceed average CPI inflation (5%) by more than 2,6%, according to the CMS’s 2011 annual report. Hospitals: 36,6%; medical specialists: 22,8% of claims; medicines: 16,3%; GPs: 7,3%; and dentists: 3,5%.

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

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

THE DILEMMA OF PRESCRIBED MINIMUM BENEFITS (PMBS)

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

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

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

The latest: In September the Supreme Court of Appeal denied the BHF and the municipal workers’ medical scheme the right to appeal against the dismissal of their application for clarity over medical schemes’ obligation to pay PMB claims at full cost. The court did not give reasons for its decision. Medical schemes supporting the BHF said this interpretation of the regulation gave providers a blank cheque to charge as much as they like for PMB services.

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

DOING AWAY WITH HEALTH INSURANCE PRODUCTS

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

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

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

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

According to a KPMG study, code manipulation and claiming for services not rendered accounted for 76.2% of fraud committed by service providers in the healthcare industry. Collusion between member and service provider was a primary cause for fraud, followed by member apathy, ignorance, and a lenient approach by regulatory bodies.

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

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

PHARMACEUTICALS

Pharmaceutical industry in SA

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

According to the draft regulations four price bands with different maximum logistics fees will apply. For medicines where the ex-manufacturer price is less than R100 (excluding VAT): no more than 8% plus R3; medicines priced between R100 and R500: 6% plus R4; and above R500 but less than R1 000: 4% plus R5. Medicines priced at R1 000 or higher will have logistics fees capped at R54.

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

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

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

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

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

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

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

Complementary medicines could not be included because they were unregulated.

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

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

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

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

**RESEARCH AND NEW DRUGS**

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

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

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

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

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

Cheaper biologics: Biologics could become more affordable and accessible if more of these drugs are distributed to state hospitals. Biosimilars, drugs that were copies of biologics, should reach SA in two to three years, and were expected to reduce the cost of biologics by 25% to 50%.

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

**GLOBAL NEWS**

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

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

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

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

Johnson & Johnson: Generic manufacturers are to be given a free rein to make cheap copies of Johnson & Johnson’s HIV/AIDS drug Prezista for sale in Africa and other poor countries. The US healthcare group said it would not enforce patents, provided generic firms made high-quality versions of the drug - known generically as darunavir - for sub-Saharan Africa and Least Developed Countries. Prezista used when patients develop resistance to older antiretrovirals. J&J has an existing deal with Aspen, which makes Prezista at a discounted price for Africa.
GlaxoSmithKline (GSK): In July it was reported that GSK agreed to plead guilty and pay $3bn to settle the largest case of healthcare fraud in US history. The settlement includes $1bn in criminal fines and $2bn in civil fines in connection with the sale of the drug company’s Paxil, Wellbutrin and Avandia products. In November GSK announced plans to buy about 321m shares of GSK Consumer Nigeria for a total of $1bn. GSK also offered to buy 13.4m shares of India’s GSK Consumer Healthcare for $940m. The offer price in both cases is about 28% above the previous last close for the shares. If it buys the maximum amount of shares in the offers, the company’s stake in the India unit will rise to 75% and its holding of the Nigeria operation will climb to 80%.

Life Healthcare: In June it was reported that Life had beaten expectations on its listing in 2010, outpacing rivals Netcare and Mediclinic - largely because it is less encumbered offshore. Life purchased a minority stake in nine hospitals in India for some R800m, opting not to expand into First World situations, where the South Africans’ ability to add value is limited. Life’s operating profit rose 17% to R2.5bn, up from R2.1bn in the previous financial year. A final dividend of 60c, up slightly on last year’s 54c was announced.

Cipla Medpro: Indian pharmaceutical company Cipla made a bid for a 51% stake in SA’s Cipla Medpro at R8.55 a share. Jerome Smith, CEO and founder of Cipla, who has resigned after Cipla Medpro’s board suspended him and charged him with a string of alleged financial irregularities, dismissed speculation that he might return to the company should Cipla India’s bid succeed. With 4.465m shares in issue, the proposed deal would be worth about R1.95bn. But analysts argued that Cipla Medpro was worth more than that. Cipla won almost 25% of the tender for the HIV triple pill that state patients will start receiving in April 2013.

Adcock Ingram with an estimated staff of 2 000 people in SA, offered a retrenchment package to workers who wished to volunteer. Adcock has had a tough trading period since the withdrawal by the MCC last year of painkillers containing dextropropoxyphene and the loss of an ARV tender worth more than R660m over two years. In July Adcock acquired the brands of Indian pharmaceutical company Cosme Farma Laboratories for R708m. Adcock reported a 19% drop in operating profit to R869m for the year to September 30, as consumers opted for cheaper products and the cost of imported ingredients rose due of the weak rand. Adcock faced steeper input costs thanks to higher water, electricity, transport and labour bills. The company reported a 2.4% increase in revenue to R4.64bn, while headline earnings per share fell 9% to 422.4c, and earnings before interest, tax, depreciation and amortisation (ebitda) dropped 16% to R986m. Turnover in its prescription business decreased by 6.9%; over-the-counter turnover rose 11.4% to R1.79bn.

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

Mediclinic International: The hospital group refinanced its entire R28bn debt facility, and said it aimed to raise R5bn with a rights issue underwritten by Remgro and had renegotiated its R24.1bn debt facilities to realise an annual saving of R550m on financing costs. The refinancing arrangements include new Swiss debt funding of R17.85bn; new SA debt of R4.2bn; a local R5bn rights offer; and a R2bn issue of preference shares. Mediclinic’s share price has risen by 25% since the beginning of this year. Mediclinic International announced the increase of its effective shareholding in Dubai’s Emirates Healthcare to 100%. The company denied that the expansion was an indication of diminished prospects in SA, and anxiety about the introduction of NHI.

Medihelp: Medihelp ended its financial year with a surplus of R163.9m and a solvency ratio of 29.2%. Medihelp has once again been awarded an AA- (minus) rating from the Global Credit Rating Company for its claims-paying ability.

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

‘FAIRER’ TAX TREATMENT

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

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

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

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

GENERAL NEWS: SOUTH AFRICA

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

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

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

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

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

Three Health Sins: Liquor, Tobacco and Obesity

‘Big Food’ taking bite out of SA health: A report from the Centre of Metabolic Medicine and Surgery (CMM5) stated 66% of women and 33% of men in SA were overweight and 10% of men and 28% of women might be morbidly obese.

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

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

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

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

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

**Battle looms over shock move to ban liquor ads:** A shock draft bill from the Department of Health that totally prohibits the advertising and promotion of alcoholic products is being reworked behind closed doors by an interdepartmental government task team. The Control of Marketing of Alcoholic Beverages Bill, seeks to: totally prohibit the advertising of alcoholic products; permit only notices (accompanied by a health warning) “describing the price, brand name, type, strength, origin and composition of the product”, to be displayed; prohibit the display of names and logos of alcoholic beverages on delivery vehicles; prohibit the linking of sports sponsorships to brand names; and prohibit the promotion of alcohol through donations and discounts at events.

A recent study by marketing analyst Chris Moerdyk found the media industry stood to lose R2-bn in revenue if alcohol advertising were to be banned - which amounted to about 2 500 job losses.

**GENERAL NEWS: INTERNATIONAL**

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

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