

FREE **HASASA**
NEWS

Exploring new healthcare frontiers

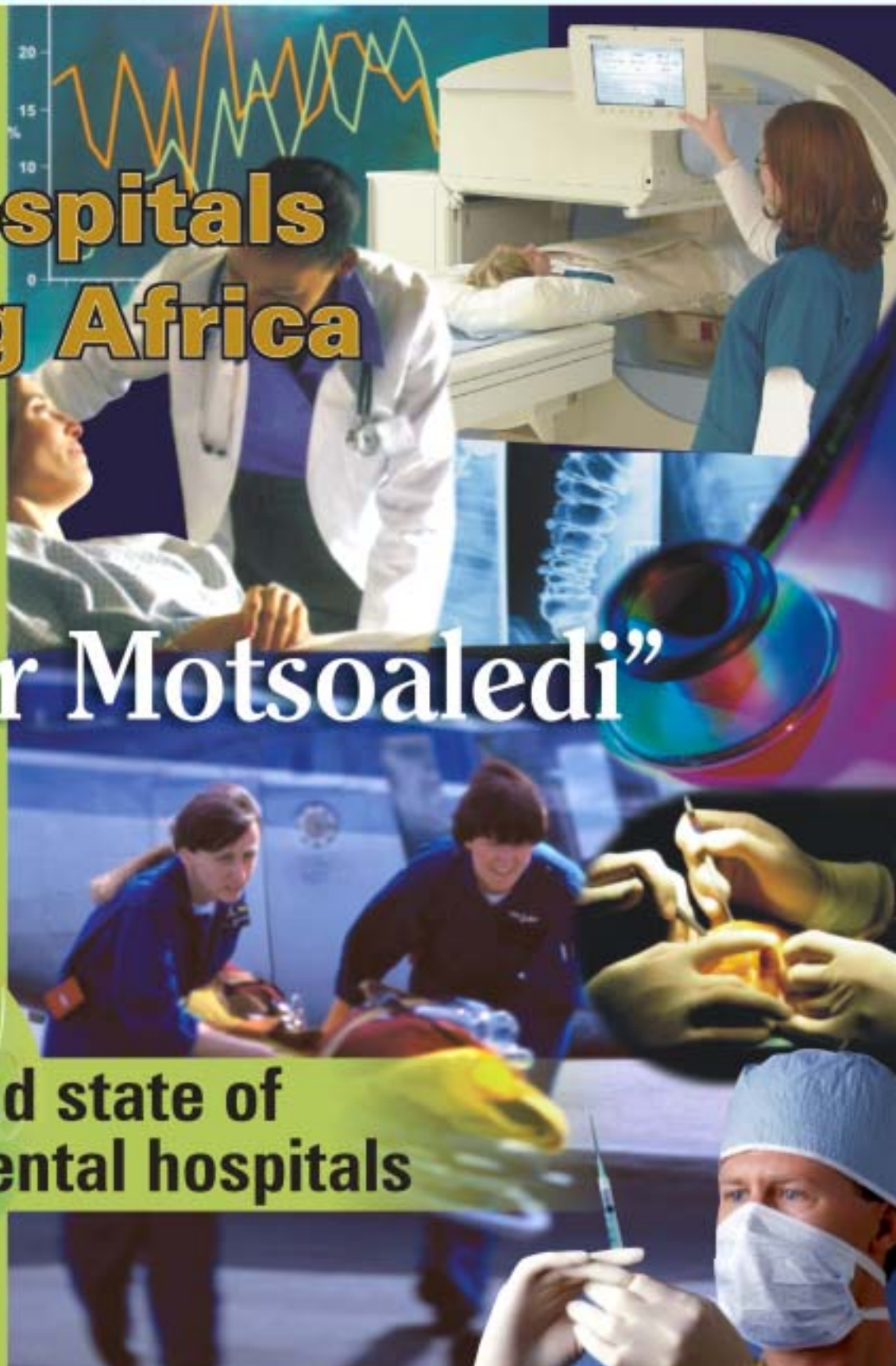


MAY/JUN 2009

**SA hospitals
eyeing Africa**

“It’s Dr Motsoaledi”

**Sad state of
mental hospitals**



The role of HASA

The Hospital Association of South Africa (Hasa) is a confederation of private hospitals and ambulatory clinics, operating on a non-profit basis, representing the collective interests of private hospitals in South Africa in respect of economic and social policy and other areas, as agreed to by its members.

The Association represents 212 group and independent hospitals, with a total of 26 868 beds, about 90% of the beds and hospitals in the private sector. Hasa is seen by government to be the official representative body for the industry and is recognised by other stakeholders as the mouthpiece of the industry.

The Association does not market individual hospitals, neither does it enter into funding contracts on behalf of its members.

The Association's affairs are governed by a Board of Directors, elected by the members, which is fully representative of the Association's membership base.

THE OBJECTIVES OF THE ASSOCIATION INCLUDE:

- + Promoting the development of an economic and social system, based on the principles of justice, a free market economy, individual entrepreneurship and equal opportunity;
- + Initiating, influencing and commenting on proposed legislation in the interests of its members;
- + Acting as a representative on behalf of its members to commissions, committees and other institutions, as decided by its members, including the Health Professions

Council of South Africa, South African Nursing Council, South African Medical Association, Council for Medical Schemes, Road Accident Fund Board, National Health Information Systems Committee (Department of Health), Commission for Occupational Injury and Diseases, Health and Welfare Sector Educational Training Authority, Council for Health Service Accreditation of Southern Africa and the Private Health Forum;

- + Liaising with other international bodies, such as the British Association of Private Hospitals, the American Hospital Association and the Australian Hospital Association;
- + Communicating and consulting with its members on important national and international developments which may impact on South African healthcare interests;
- + Acting as a communication hub, to inform and advise its members through, amongst others, workshops and conferences at both regional and national levels, a monthly newsletter, LegalWatch, NursingWatch, Hasa Watch and a prestigious annual publication;
- + Investigating complaints and acting as a mediator in dispute resolutions in matters arising from patient or member complaints; and
- + Marketing the competence and ability of its members to the public, which is accomplished through media liaison, press releases, public addresses and the placement of advertorials in the press.



For further information on HASA you can access our website www.hasa.co.za or tel 011 478 0156.



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It's time to face the challenges

Lucas Malambe, Editor Hasa News

Now that the election posters are fading and going down, South Africa has a new president and a new Minister of Health in Dr Aaron Motsoaledi, it is time for all to put shoulder to the wheel. Hasa's CEO, Adv Kurt Worrall-Clare, welcomes the appointment of Dr Motsoaledi as head of this industry on page 4.

Motsoaledi is replacing the affable Barbara Hogan, now the Minister of Public Enterprises. He will have to work hard to endear himself to all the healthcare stakeholders. Motsoaledi will have little time to savour his appointment. The health ministry has a long to-do list that needs his urgent attention. He is inheriting an ailing public health system, unhappy health workers and the establishment of the mooted National Health Insurance (NHI). This will not be an easy task considering there is also the burden of HIV/Aids and TB to contend with.

Establishing the NHI in five years, promised by the ANC manifesto, will be a tricky affair. Many disbelievers are quick to dismiss the NHI as a very ambitious plan. NHI promises to provide medical insurance for all to ensure access to quality healthcare is not a privilege of the few. However, the sceptics believe that government should rather focus on improving the basic working conditions (including salaries) of healthcare workers and infrastructure. At the time of going to press, public healthcare doctors were planning to intensify their strike if the government fail to adjust their salaries by up to 50% to put them on par with other professionals in the public sector.

In the offing, however, the rhetoric around NHI rages on and it appears to be pointing in one direction only, namely full medical insurance that is fully controlled by the state.

Medical insurance that says everybody in and nobody out sounds good, but the abode of control is likely to be divisive.

Does control mean control through legislation or through an administrative company run by the state? That is likely to give funders nightmares, but providers will also be asking how the type of administration will impact on patients' free choice of doctor and hospital.

The choice of control, in my opinion, should be driven by a desire to cut out non-healthcare costs, guarantee choice of health plans and medical providers and ensure that all South Africans have access to affordable coverage. Ensuring the patient has choice of treatment and service (how and by whom) will strengthen the country's health system by increasing provider competition. These aims can only be realised through honest and vigorous debate which pool all stakeholders.

The sticky point will be how to ensure that the industry does not lose the skills and experience and resources presently residing in the funding industry. The uncertainty around this is, quite rightly, responsible for the sector's uneasiness. Furthermore, the rhetoric coming from some bigwigs in government is not helping to shape the envisaged honest and research-driven argument on NHI.

NHI will be effective if it helps everybody, especially the poor, by injecting competition into a healthcare market that in many areas is dominated by a handful of major insurers and administrators. There is no need to promise "war" on each other even before the issue is officially on the table. Let's rather talk about how to best set up such a plan without disrupting the system for people who already have coverage.

LETTERS

to the Editor

DO YOU HAVE A BONE TO PICK?

Email us your views with name, address and phone number to: contact@hasa.co.za

FM reader responds to Makgetla

Neva Makgetla repeats a common error in her column (SA needs a remedy for the high cost of private healthcare, *Financial Mail*, May 14). The percentage of gross domestic product spent on healthcare is irrelevant. What counts in terms of healthcare delivery, is the absolute amount of money per capita spent.

As most medicine/technology is imported, the US dollar amount we spend determines what we can give. The state spends R1 350 per person per year on health. This equates to under \$200. Compare this with the UK's spend of approximately \$3 000 and New Zealand's \$2 000.

We clearly cannot expect to deliver a first-world healthcare plan on that tight a budget. Yet we probably cannot afford to spend more than 11% of the budget on health.

The Department of Health maintains that money spent on private healthcare is part of the same pool and that they should have the right to redistribute private health money over the entire population. This would have obvious repercussions as it essentially means the nationalisation of an entire sector of the economy and it would have limited effect. It would still leave the total per-capita spend at only about \$400 per person per year.

SA's private health system is rated seventh-best in the world this year and is only the 22nd most expensive. At \$907 per capita, it is far cheaper than the UK and New Zealand systems run by their governments, and it gives better service. So Makgetla is wrong when she says our private healthcare system is expensive.

Why destroy a model that has produced an economic sector that is one of the most efficient in the world?

If private healthcare is constrained so that we cannot offer a first-world level of healthcare, imagine the effect that this will have on all the other educated (and thus highly mobile) South Africans. They will follow our doctors overseas.

The department needs, thus, to decide what can reasonably be expected to be delivered on \$200 per head per year. A national health insurance covering only preventative and primary care at first will already make a massive impact on the healthcare received by the poor, and should be affordable.

Dr Greg Ash

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Exporting health to Africa

Shoks Mzolo, *FM*, 08 May 2009

Mozambicans who travel hundreds of kilometres for medication and healthcare in SA may soon be able to save themselves the journey – and in other Southern African countries residents can look forward to the prospect of better treatment too.

SA healthcare groups are eyeing new investments in several regional countries. One of the busiest is Lenmed Health. Its chairman, Prakash Devchand, talks of Mozambicans travelling across the border to buy Gaviscon, an anti-heartburn medicine. Lenmed has teamed up with a Mozambican company, Invalco, to build a 110-bed hospital in the capital, Maputo. Netcare is involved in a R1bn project to rebuild a 390-bed hospital in Lesotho.

Southern African countries are keen to welcome SA investors. These include Angola and Zimbabwe, where there are signs of economic reconstruction. In Mauritius, Hasa has been invited to conduct what CEO Kurt Worrall-Clare says are “preliminary studies”.

Lenmed’s Mozambican project is at an advanced stage. “We’re at rooftop level and on track to launch in October,” Devchand says. In SA, Lenmed runs four hospitals (a capacity of nearly 450 beds) and has a stake in Pharmed, a drug wholesaler. With Invalco and a European banker, Lenmed’s first cross-border project is the US\$17m Hospital Privado de Maputo. Lenmed director Ahmed Nana says the hospital will include a 24-hour trauma unit and a five-bed intensive-care unit. Nana, who has spent the past few months shuttling between Johannesburg and the building site in Maputo, says it expects to admit 500 to 1 000 people each month.

This is just the beginning, says Devchand. Lenmed will eventually run four hospitals in Mozambique, which is home to 22m people. Its second project is a 50-bed hospital in Nampula, 1 500 km north of Maputo. Construction in Beira will commence next year. Then it’s off to remote Tete, which should also cater for Cahora Bassa and



attract patients from Malawi and Tanzania, he says.

But could Lenmed be trying to do too much too quickly? The company is also sizing up opportunities in the Democratic Republic of Congo. “The Mozambican opportunity was dropped in our lap. We feel we’re ready, but we’re not going to push it too quickly. We’ve done our homework,” says Devchand. He adds that the Mozambican government “is behind us. It wants private healthcare there, because it will also contribute to skills development and job creation.”

He adds that Lenmed has experience of Mozambican patient demand. “Our Lenasia branch gets patients from Mozambique. Some of them go to Nelspruit, others go to Johannesburg. There’s certainly good demand.”

The skills shortage was expected to frustrate the project, but Nana is “pleasantly surprised” by how many

medical practitioners are keen to work in Maputo. However, the number of nurses remains low. To this end, the Netherlands’ Fontys University will train locals. For now, Lenmed will consider importing nurses from other countries, says medical director Farouk Kaka, who has been with the group since inception in 1984.

Lenmed started out as a small hospital, built with R2,5m in contributions from Lenasia’s community. It has grown into an operator that churned out R42m in post-tax profits in the past financial year.

“In the old days, black doctors were not allowed to practise in white areas and black patients were barred from going to white hospitals, so it made sense for the community and doctors to build their own facility. Banks didn’t fund us, so we went door-to-door in Lenasia to raise funds and invited business people to invest,” Devchand says.

Lenmed’s footprint also covers Johannesburg and KwaZulu Natal, but it wants to become a national player.



SOLID FOUNDATION to build on

Adv Kurt Worrall-Clare, Hasa CEO

HASA IS PLEASED WITH AND WELCOMES THE APPOINTMENT OF THE NEW MINISTER OF HEALTH, DR PAKISHE AARON MOTSOLEDI, AND THE DEPUTY MINISTER, DR MOLEFI SEFULARO.

Congratulations to the Minister and Deputy Minister of Health on their appointments. The private hospital industry is looking forward to building a positive relationship with the new minister and his team. We hope that Dr Motsoaledi will look to the private sector as a partner who can assist in developing solutions for the healthcare issues facing the country.

The private hospital sector is fully committed to engaging with government and participating in the important task of transforming the country's healthcare system so as to broaden access and affordability. Dr Motsoaledi will not only bring managerial expertise to the Department of Health, but also a deep understanding of healthcare and medical issues. This will stand him in good stead as he tackles the challenge of getting the National Health Insurance system off the ground.

Having been a practising doctor in rural areas as well as holding a number of high profile government positions, Dr Motsoaledi has a wealth of experience that will equip him to run the health portfolio. Hasa is optimistic that the new minister will continue to encourage genuine dialogue between the public and private hospital sectors. Hasa hopes that the more open approach initiated by former Health Minister, Barbara Hogan, and Deputy

Minister, Dr Molefi Sefularo, will remain in place.

In a short time, a solid foundation has been laid and task teams were put together to improve standards in the healthcare sector. With Hogan, Sefularo has done much to build bridges, encourage partnerships and correctly identify critical needs within the Department of Health. We look forward to building on this groundwork.

HASA CONFERENCE 2009

This year, Hasa has chosen the theme of "Working Together Towards Universal Healthcare" for its annual conference, held from 3 to 5 June in Durban. As the country debates moving towards a National Health Insurance system, it's a theme that is particularly relevant to all players in the healthcare environment, both public and private. The theme is consistent with Hasa's commitment to building bridges and creating spaces of dialogue between players in the healthcare sector, even where there may be differences of opinion. The conference will provide an opportunity for delegates to collaborate and work together to draw up a roadmap to healthcare reform in South Africa.



How governments can stop the aggravating plague of fake drugs

Julian Harris,
Business Day, 11 May 2009

In hindsight, this was a predictable consequence of the swine 'flu outbreak: devious websites have begun offering fake cures. It is merely the latest adaptation of a swinish global counterfeit drugs industry, which, like a 'flu virus, cleverly yet sinisterly mutates to exploit the poorest patients.

"Time and time again... following a global threat or natural disaster, criminals exploit the situation," says Interpol's executive director of police services, Jean-Michel Louboutin.

A study by the US Centre for Medicines in the Public Interest predicts that global sales of counterfeit drugs will be worth \$75bn by next year, nearly double the 2005 figure. All parts of the world are affected, with Africa being the prime victim.

The common reaction is to call for government action and the common response is a clampdown: more laws, more regulation and more inspections.

We should, however, be wary of government, largely for one reason: corruption. Health sectors throughout the world are particularly susceptible, with the 2006 Global Corruption Report noting how officials frequently "demand 'fees' for approving products... and counterfeit or other forms of substandard medicines may be allowed to circulate".

An example of this emerged recently in India. In Orissa, a strong drug controller

procured medicines for the state health department, with separate drug inspectors checking them. Sounds robust? Sadly, inspectors and officials of the drug controller were in league with counterfeit producers, and supplied fake drugs to hospitals.

Increased regulation often does little more than increase opportunities for corruption, playing into the counterfeiters' hands.

So what can governments do? It can stop making the problem worse. Many of the root causes of drug counterfeiting are made worse by government interference, such as price controls and taxation. Price controls may aim to make drugs cheaper, but they can have dire consequences. They deter companies from registering their medicines in a market, hence reducing competition – which is the best means of keeping prices down in the first place. Also, the purveyors of high-quality medicine may well have the highest costs (due to high manufacturing standards) and thus be the most deterred, while producers of cheap, sub-standard drugs and fakes will be encouraged to enter the market.

Price controls also cause shortages in medicines, creating a gap that counterfeiters then fill. An article in the *British Medical Journal* on Indian price controls reports that "drugs became unavailable... and a black market – as well as spurious and counterfeit drugs – flourished".

Price caps in SA resulted in the closure of at least 103 small, rural pharmacies,

because they had to charge more than large, urban shops. Previously, the rural poor could choose whether to pay more locally or travel into the cities for cheaper drugs, but now they must travel – or buy them locally from peddlers who sell fakes.

One must ask why governments impose price controls when simultaneously driving up medicine prices with taxes and tariffs.

A World Health Organisation report in May 2006 stated: "Taxes and duties levied on medicines, as well as the mark-ups applied, frequently contribute more to the final price than the actual manufacturers' price does." The previous year a study found that government-imposed measures such as taxes and tariffs adds a world average of 68,6% to the cost of imported pharmaceuticals. By artificially driving up prices, taxes create an opportunity for illegal, unregistered drugs to undercut high-quality versions.

Counterfeit drugs are a growing worldwide threat to health, worsened by government policies. Instead of declaring periodic crackdowns, governments should back permanent vigilance and the rule of law. They should also reduce the market distortions that help the counterfeiters, such as price controls, taxes and tariffs. Your life may depend on it.

■ *Harris is a research fellow at International Policy Network, an international, non-governmental, educational and nonpartisan development think-tank.*

Politicians do not use state facilities

Nosimilo Ndlovu,

Mail & Guardian Online, 29 April 2009

Hhealth topped almost every political party's election manifesto – yet some of the leading politicians who used health concerns in their campaigns avoid South Africa's crumbling public healthcare system.

ANC secretary-general Gwede Mantashe told the *Mail & Guardian* he finds public health extremely inconvenient. "I think everyone uses the doctor that's closest to him in the neighbourhood. And in my case that's a private one," he said.

Mpumalanga Health Minister, Fish Mahlalela, also confirmed that he did not use state facilities, stating that to do so would be to deprive poor people of access.

National Health Minister Barbara Hogan said she hasn't used the system since she moved into the Cabinet last year, adding that she has a private doctor. "I've had no necessity for healthcare for a while. I'm very fortunate," Hogan said. She agreed that it would be unreasonable to expect South Africans to have confidence in a system that she does not use herself.



Hogan's deputy, Molefi Sefularo, said he would use the public health system only if he needed to be hospitalised. For lesser complaints, he used a private doctor. "Ideally, we think all leaders should be able to use the public health system, but we would like to get to a point where it's ultimately a matter of choice, where the quality between the public and the private is equal. The tragedy now is that people don't have a choice."

Health activists said it was essential that government leaders acted as role models.

"The country's health system will never improve if the people who create it, who are responsible for it, don't use it themselves," said Thobile Mbengashe, director of the advocacy organisation, Health Systems Trust. "How will they know how it feels to use it and what to improve? Ultimately government should ensure that the health services of the public and private sectors are equal and provide service of the same quality."

Arguing that public healthcare is in a bad state, largely because it is overloaded, Mahlalela said he uses private healthcare to take pressure off the state system.

"The more members of our society that can afford health insurance and make use of it, the better our public health system will work, as it will be less stretched," he said.

Gauteng health minister Brian Hlongwa, Limpopo's Seaparo Sekoati and KwaZulu-Natal MEC Penny Nkonyeni all claimed that they use public healthcare and are satisfied with the service. However, they did not provide examples.

Phillip Dexter, spokesperson for the Congress of the People, said it is no surprise that provincial ministers either do not use public healthcare or cannot come up with clear examples of how they used the system. "Generally, the public healthcare system is under-resourced and poorly managed; the queues are long and you are not guaranteed good treatment."

The DA's health spokesperson in Gauteng, Jack Bloom, said that if health ministers are forced to use the state system, public healthcare would improve radically. "Forcing health MECs to use the public health system would be a personal incentive to fix up public health," Bloom said.

HEALTH AWARENESS

JUNE

National Youth Month / National Blood Donor Month

1	International Children's Day
7	National Cancer Survivors' Day
4	International Day of Innocent Children - Victims of Aggression
5	World Environment Day
14	World Blood Donor Day
15	World Elder Abuse Day
16	Youth Day
15 - 21	National Epilepsy Week
21	National Epilepsy Day
22 - 26	National Youth Health Indaba
22 - 28	SANCA Drug Awareness Week
26	International Day against Drug Abuse and Illicit Drug Trafficking

Medical costs and retirement



Summit TV personal finance expert Bryan Hirsch discusses funding medical healthcare costs in retirement with Heidi Kruger from the Board of Healthcare Funders (BHF) and Dr Jonathan Broomberg from Discovery. This is a shortened version of the full transcript, which is available on www.summit.co.za.

Bryan Hirsch: Welcome to *Your and Your Money*. Medical aid membership is an essential part of your overall financial planning, but due to the increase in healthcare contributions members are asking whether there are effective ways of saving costs. However, one needs to be very careful before reducing benefits of your current medical aid. The government has announced a national health insurance (NHI) system for South Africa and President Zuma said on Workers' Day it will be implemented despite the nay-sayers, which is perhaps exciting and something to look forward to. To talk about the up and coming changes in the medical industry, we are joined by Heidi Kruger, head of corporate communications at the Board of Healthcare Funders (BHF) and Dr Jonathan Broomberg, head of strategy and risk management at Discovery. My first question is how big a departure is this two-way system, how long is it going to take to implement, and who is going to pay?

Dr Jonathan Broomberg: I don't think we really know yet what the proposed NHI system will actually look like. If you look at healthcare systems around the world, there are literally dozens of different healthcare systems, all of which go by the name of national health insurance. There are some models that are being debated out there, but so far government has not put anything concrete into the public domain.

Bryan Hirsch: So it's a bit early for all the hype. Are we talking one year, five years or ten years? We look at all the changes to taxation and pension funds and it's early days still...

Dr Jonathan Broomberg: I think it is. It's also important to make the point that we need to deal with fundamental issues here. Everyone is entitled to healthcare, but the problem is that the public healthcare system is broken and is delivering very poor quality care to the people of South Africa. There's also under-funding of the healthcare system, so I think what the new Minister and his new civil servants will have to focus on is fixing up the basics of the healthcare system.

Bryan Hirsch: Heidi, too few contributors? Has the private system only got a small percentage of contributors the rest really waiting for some sort of NHI?

Heidi Kruger: Dr Olive Shisana, who heads up the NHI task team for the government, has said that working people will contribute 3% to 5% from payroll, and there will also be increased tax allocations to make NHI affordable. She envisions a comprehensive set of benefits for every South African, with the public sector being the backbone for providing the service. As Dr Broomberg says, the details are sketchy at the moment, but it seems that the government is resolute about bringing it in.

Bryan Hirsch: What is the role of the BHF?

Heidi Kruger: The BHF is a representative body. We used to be Rams in the old days. In those days we were statutory, mainly bargaining tariffs and managing the PCNS practice code numbering system. Then, slowly, the institute body became non-statutory and became the BHF, a representative body for medical schemes.

Our primary functions are PCNS, lobbying and engaging with government on strategic and legislative issues.

Bryan Hirsch: Everyone is saying that with medical inflation being a lot higher than general inflation, there's difficulty finding that balance between what the doctors charge and the needs of the consumer. Where does that fit in?

Dr Jonathan Broomberg: You've identified a really important issue. Healthcare inflation is a global issue. You can see that in the US, where healthcare accounts for 16% of US GDP. This is a problem all over the world. As populations get older and as technology advances more equipment and new drugs are invented that genuinely achieve new outcomes and better outcomes, costs do increase. This is a problem that health insurers and healthcare funders all over the world face. It's our job to try and balance, making sure members have the maximum benefits they need, but with sustainability so that premiums are not too far off the annual wage increases.

Bryan Hirsch: We've got Sarah on the line...

Sarah: I would like to ask: Is a retirement annuity a good way to save to eventually pay for medical expenses?

Bryan Hirsch: An interesting question. Very simply you get the tax reduction on a retirement annuity prior to retirement. Obviously, at retirement you get a certain amount in cash, and with the balance you buy a pension and that's taxable. However,

over the age of 65 all medical expenses are tax deductible, so on the one hand you've got money coming in that would be taxable, and if you've got money going out and it's deductible. Yes, it is a good way, bearing in mind those medical costs are going to increase.

Bryan Hirsch: Let's go back to that question I raised a moment ago. With medical technology you hear of all the changes. How is that going to affect long-term costing and, more importantly, are medical aids going to pick up these costs?

Heidi Kruger: As Johnny said previously, it's a balancing act, giving members the most benefits you can for the money that you collect from them. There is new technology all the time, expensive technology, so it's a very difficult balancing act.

Bryan Hirsch: That's a problem, because you go to a doctor who says I want you to go through certain tests. You've obviously got to get permission, and that's where the conflict comes between what the doctors are recommending and what medical aids are prepared to fund. How do you balance that?

Dr Jonathan Broomberg: You're pointing to a very complex problem. In Discovery's view, the most important solution to this is information. We are on a big drive to inform our members and the doctors, whom we regard as partners, of the costs and benefits of new technology. Not everything that's brand new is necessarily superior to what came before, particularly when you take the cost into account, so we and many other funders all over the world, including government, use a concept of cost-effectiveness. It may be a new product or drug that may have a benefit, but the question is if it costs ten times more than the product it's replacing, is the benefit ten times greater? We believe if we inform our members and the doctors about the balance between the cost and benefits, the system will ultimately maintain sustainability.

Bryan Hirsch: Jonathan, where is the most money spent?

Dr Jonathan Broomberg: It's spent on a balance of different things. Firstly, hospitals probably take up around about 30% to 40% of any medical scheme's expenditure. Medicines and equipment used in hospitals make up another 30% and then there's expenditure on doctors, specialists, radiology and pathology. That will take you

up to about 80% to 90%. Between 10% and 12%, depending on which medical scheme, is spent on administration, risk management and so-called managed care services for the collection of premiums and the payment of claims. Then, depending on the solvency level of a medical scheme, some of the premiums may go towards building up reserves.

Bryan Hirsch: Heidi, does that mean members who don't claim at all should be downgrading their medical aid?

Heidi Kruger: Not necessarily, for two reasons. One is that you don't know what's going to happen. You might have a catastrophic event and you might need all the hospital cover you can get. The other reason is that you wouldn't downgrade lightly. You would need to know what the chronic disease profile in your family is, what you can afford and what the limits are on the lower options. We have seen people doing it now with the economic crunch, but not that many people.

Bryan Hirsch: There's a danger in downgrading that members don't always understand?

Heidi Kruger: Certainly. If you go for a hospital plan, it might cover you for the prescribed minimum benefits and some chronic conditions, but with hardly any day-to-day cover.

Bryan Hirsch: An e-mail from Mark in Gauteng asks what members need to watch out for with lower cost cover.

Heidi Kruger: There may well be a hospital limit, for example, so the medical scheme may not cover you above a certain limit, or there might be co-payment for specialists, doctors and even medicines. You may not be covered for what you want to be covered for.

Bryan Hirsch: So, medical aids are not just medical aids, there's a lot of differences, and one of the critical differences you speak about is limits...

Heidi Kruger: That's probably the most important difference between the higher options and the lower options.

Dr Jonathan Broomberg: I think it's very important for members to understand that medical scheme cover is about insurance for the hopefully very rare event when you or someone in your family needs major cover, because there's been a catastrophic illness or a car accident or something like that.

Even if one goes through many years of paying in more than you claim, that's because when something happens that requires major expenditure the medical scheme is there for you, and when you get older and you're more likely to have chronic illnesses, that's when the medical scheme is there for you. We have tens of thousands of members in Discovery that every year are admitted to hospital and have cover that's often paid out into hundreds or thousands or even millions of rand. We can tell you stories of people who end up having reimbursements that would take 100 years to pay back in premiums. That's the basic principle of insurance which we believe is very important for members to understand. Downgrading may give you short-term relief, but could cause tremendous problems if there is medical need in the family.

Bryan Hirsch: Sarah from Limpopo asks how does the change in the Road Accident Fund affects medical aids?

Dr Jonathan Broomberg: The changes in the Road Accident Fund have had a negative impact on medical aids. What used to happen, is that if one of our members was injured and needs hospitalisation, Discovery would immediately pay the hospital account and then work with the member and attorneys to recover as much of those funds from the Road Accident Fund as we could.

Bryan Hirsch: Is the Road Accident Fund what we used to call third party insurance? Is that what we actually pay for when we pay for petrol?

Dr Jonathan Broomberg: There has been some big changes to the fuel levy. Firstly, medical expenses are no longer reimbursed by the Road Accident Fund at the cost private hospitals charge. It's reimbursed at about 60% of that level, the level that provincial or government hospitals charge. That means a medical scheme is unable to recover from the Road Accident Fund all of the hospital claims paid out. There are also other changes that means attorneys are much less engaged now in pursuing claims against the fund, and that makes it much harder for medical schemes to recover money that's actually owed to them.

Bryan Hirsch: Does the change affect the member?

Dr Jonathan Broomberg: Yes, because the medical aid is in a sense acting as the

insurer of first resort. One could argue that the Road Accident Fund should be that insurer, but we've always believed that we should there for the members immediately. They don't want to wait months to get a claim paid by the Road Accident Fund, so Discovery would step in and then collect the money from the Road Accident Fund.

Bryan Hirsch: Chantal is on the line...

Chantal: How would I choose a financially viable medical aid?

Bryan Hirsch: The average member doesn't have the ability to do a due diligence and understand how viable a scheme is and what the reserves are?

Dr Jonathan Broomberg: Absolutely. The first point is to find a reputable broker who can inform you about the options that you have, someone who can understand your financial situation and what kind of medical scheme is most suitable for you. As some

pointers I would look for size. I think you want a large medical scheme, because that tends to be much more stable and able to deal with ups and downs in the medical scheme environment. You could look at the solvency level of the medical scheme, you could look at the range of options that are available and, obviously, at the premiums, making sure that you're getting good value for money.

Bryan Hirsch: How does the South African private sector perform in terms of cost and quality relative to other countries?

Dr Jonathan Broomberg: I think we have a great asset in this country in the private healthcare sector. At Discovery we've done two studies over the last five years in which we compared how South African private healthcare compares to healthcare systems in about 50 other countries. Our private healthcare system ranks in the top six or

seven in the world in terms of both quality of healthcare and cost.

Heidi Kruger: I agree. I think there is one thing missing from our private healthcare system and that's proper health technology assessment. We don't have one national body that can assess technology, whereas the sophisticated countries have.

Bryan Hirsch: The South African public healthcare system that serves about 90% of the country's 47 million is failing many and especially the most vulnerable, according to a report published on 16 April 2009 by a human rights oversight body. The same report states that healthcare is a constitutional imperative and the government has an obligation to provide healthcare services for everyone. With the new Cabinet in place there is no excuse for tardiness or delays. We look forward to the future of healthcare in South Africa.

Where are the nurses?

The private hospital industry celebrated International Nurses Day on 12 May, saluting the major role nurses play in healthcare. Amid the fanfare it was difficult to ignore the acute shortage of nurses in South Africa. This is the result of graduates leaving the country in search of better working conditions elsewhere and poor planning regarding training. We are not training a sufficient number of nurses to accommodate the emigration of skills and the increase in population. The situation is compounded by the fact that SA is suffering from a triple health burden of diseases made up of illnesses caused by poverty and under-development, injuries and chronic diseases such as HIV/Aids and TB.

The trade union Solidarity issued a report on the day, claiming that South Africa's ratio of health workers per 100 000 people is dwindling. This should be cause for concern. It can only mean the quality of South African healthcare is under threat, unless more nurses are made available.

South Africa currently has 468 health workers for every 100 000 people. In comparison, the global average is 607 health workers for every 100 000 people. This means that South Africa has for every 100 000 people nearly 140 health workers less than the global average and about 830 less than in Europe. Nonetheless, the SA ratio is still above the World Health Organisation's minimum standard of 228 health workers for a million people.

Solidarity's analysis seems to agree with the 2004 Human Sciences Research Council study that showed that nearly a fifth of registered nurses are no longer active practitioners. The Solidarity report further claims 40% of the positions for registered nurses in the public sector are vacant. This will be further worsened by the fact that almost half of the nurses registered with the SA Nursing Council will be retiring as they reach retiring age of 50 and above. The long and the short is, we are not training enough new nurses to accommodate the increase in population and the emigration of graduate nurses.



SA's sad state of mental healthcare

Disturbing research shows the link between poverty and mental health is a strong one and access to care is severely limited when finances are tight. The Mental Health and Poverty Project (MHaPP) at the Department of Psychiatry and Mental Health at the University of Cape Town aims to evaluate the link between poverty and mental ill-health and break this negative cycle by ensuring the poorest communities have access to mental healthcare.



Evidence is emerging from low- and middle-income countries indicating that mental ill-health is strongly associated with poverty and social deprivation. Living in poverty, low socio-economic status, exposure to stressful life events like crime and violence, inadequate housing, unemployment and social conflict, are all linked to mental ill-health.

Poverty is also associated with exclusion, isolation, feelings of disempowerment, helplessness and hopelessness, which can lead to chronic insecurity and social mistrust, affecting people's mental well-being.

Not addressed in mental health policies

In spite of the political freedoms and human rights advances, there has been a growing trend of economic inequality, poverty and unemployment, which has marked the social, economic and political landscape in South Africa. To date, the link between poverty and mental ill-health has not been sufficiently addressed in mental health policies and programmes in South Africa.

Clinical, social and economic interventions can positively benefit the mental health of South Africa's communities, yet mental health is not given the priority it deserves.

MHaPP's fieldwork was conducted between 1 August 2006 and 31 March 2007, using data requested from services for the 2005 calendar year. The study aimed to show that the vicious cycle of poverty and mental ill-health can be broken through a range of interventions, including providing cost-effective mental healthcare in community settings and through a multi-pronged approach to the problem, with support from a range of different government, NGO and private sector initiatives.

Shocking statistics

The MHaPP study found that mental health is not at the forefront of policy development and implementation in the health, education, employment, social development or other key sectors in South Africa, and there is little co-ordination of mental health across these sectors. "We knew that mental health services were under-resourced in South Africa, and that mental health has always

been low on the priority list – but what surprised us was the level of inequality between provinces," says Dr Crick Lund, Chief Research Officer of the Mental Health and Poverty Project.

"In the public sector there is a 45-fold difference in the number of psychiatrists between the North West (1 psychiatrist per 5 000 000) and the Western Cape (1 psychiatrist per 110 000).

"When we look at beds in community residential facilities, this varies from 0 in the North West and Northern Cape to 6,5 beds per 100 000 population in Gauteng." But this does not mean the Western Cape and Gauteng are over-resourced, warns Dr Lund: "Clinicians and facilities in Gauteng and the Western Cape are stretched to the limit. What this shows us is that certain provinces are not taking mental health seriously as a public health and development issue."

National problem

Mental health services and human resources are limited across South Africa, with 0,28 psychiatrists, 0,45 other medical doctors, 10,08 nurses, 0,32 psychologists,

0,4 social workers and 0,13 occupational therapists per 100 000 people in the country. There are 41 psychiatric in-patient units in general hospitals in the country with a total of 2,8 beds per 100 000 people.

For South Africa's over 40 million population, there are only 23 public mental hospitals, providing 18 beds per 100 000 people — only 1% of these beds are reserved for children and adolescents — and the number of mental hospital beds has decreased by 7,7% in the last five years.

Suicidal patients turned away

The Department of Health reported to MHaPP that 53% of hospitals have been listed to provide 72-hour assessments of psychiatric emergencies, in keeping with the provisions of the Mental Healthcare Act. However, there remain major concerns about the capacity of staff and facilities to provide adequate mental healthcare in these hospitals. "Far too often critically suicidal patients have to wait for hours to be admitted, and often they are turned away due to lack of space," says Director of the South African Depression and Anxiety Group (SADAG), Zane Wilson.

"Frequently mentally ill patients will be admitted to general wards if there is no separate psychiatric in-patient unit. This increases stigma and decreases the quality of care for these patients."

The MHaPP study concluded that public attitudes toward mental health and treatment conditions remain generally negative and — despite a progressive and supportive policy framework for mental health and in spite of all the emerging evidence of interventions that could enable us to address mental health systematically in this country — mental health is not given the priority that it requires in South Africa and remains a low priority on the public sector agenda. Dr Lund says that it costs our economy more to ignore the burden of mental disorders than to provide appropriate resources.

"These conditions can be accurately diagnosed and effectively treated if we are prepared to commit the resources and change the way we think about them."

Sapa, May 2009

ENERGETIC *performance*

Mia Malan, Mail & Guardian, 15 May 2009

A collapsing public health system, demoralised health workers and the implementation of a complex National Health Insurance scheme loom large among the challenges facing new Health Minister Aaron Motsoaledi.

A cceptance by the country's health community could be another. Health activists are disappointed that President Jacob Zuma has not retained Barbara Hogan to lead efforts against public health crises, not least HIV/AIDS.

With her strong financial background and inclusive style, Hogan became popular during her short tenure. Many in the health field responded cautiously to former Limpopo education minister Motsoaledi's appointment.

The Treatment Action Campaign (TAC) warned that a strong financial background, which Hogan has, is essential in managing the health portfolio, and that Motsoaledi must closely monitor the often overspent budgets of provincial health departments. The TAC voiced concern about the government's under-budgeting for antiretroviral drugs, which interrupted treatment in the Free State earlier this year. Free Staters are dying as a result of this "catastrophe", it said.

Motsoaledi's performance will also be judged by his handling of negotiations around the Occupation Specific Dispensation (OSD), the forum in which state health workers' salaries are renegotiated. A recent breakdown in the talks prompted an illegal strike by doctors demanding pay rises of between

50% and 70% to give them parity with other public servants. Ashraf Coovadia, of Johannesburg's Rahina Moosa Mother and Child Hospital, warned that unless this topped Motsoaledi's agenda there will be "dire consequences for an already strained healthcare system".

One of Motsoaledi's toughest tasks will be to implement the ANC's controversial National Health Insurance scheme, which could double the costs for South Africans with private health insurance.

Newly appointed director of hospital services Eddie Mhlanga, who has studied and worked with Motsoaledi, said the new minister is up to the challenge: "He's a superb implementer, speaks his mind and listens to what people have to say."

The president of the Democratic Nurses Organisation of South Africa, Thembeka Gwagwa, also studied with Motsoaledi and is a fan.

"He's extremely energetic and accessible," she said. "We hope he'll give nurses the respect they deserve — we're the backbone of the health system."

Motsoaledi served as Limpopo's education minister from 1994 to 1998 and again from 2004 to 2009, and as health and agriculture minister. Education insiders generally speak well of him, but one also commented that he is "sometimes a bit of a loose cannon".

"Part of why we had agreed to suspend our strike was that we had agreed to work together with [the association], but now they have apparently reached an agreement with the Health Department behind our back," said Rapiitse Malatji, spokesman for the United Doctors' Forum – the group representing the disaffected doctors which broke away from the SA Medical Association (Sama) – arguing that the forum would not recognise decisions reached in its absence and accusing the association of betraying the doctors.

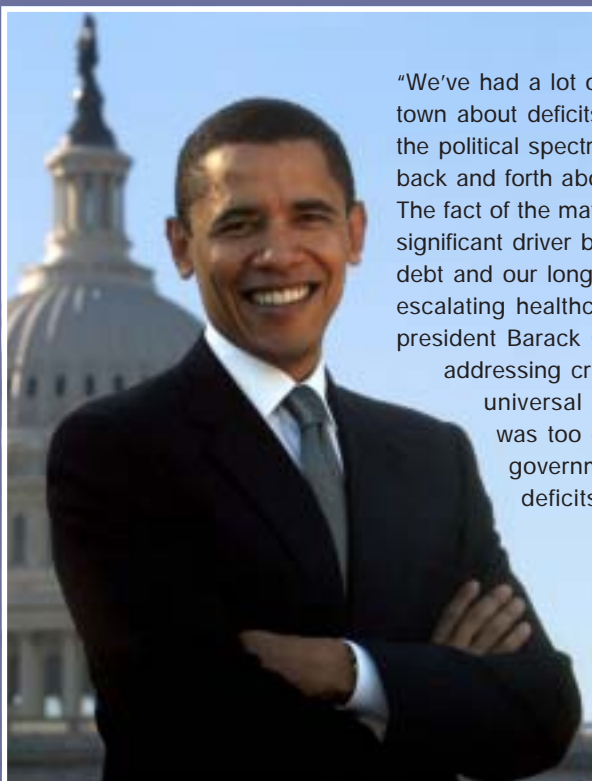
"It is not true that we have signed a deal. We are still giving the negotiations a chance." Mkhululi Lukhele, chairman of Sama's the public doctors's desk.

"We only recognise the Medical Association and cannot negotiate with those who walked out of it." Fidel Hadebe, after the UDF issued a statement pouring scorn of the wage negotiations.



"We've been through turbulent times, we've been hit by a tsunami and there's been a lot of internal conflict... We're now strengthening the organisation

in all respects, because we can't stand back and say 'there's nothing wrong with us'. We want to be relevant to all members – both in the public and private sectors. We're in a sort of a watershed time. Sama must get its act together," said Denise White, acting chairperson of Sama, acknowledging her organisation has been stumbling from one crisis to another in recent times.



"We've had a lot of discussions in this town about deficits, and people across the political spectrum like to throw barbs back and forth about debt and deficits. The fact of the matter is the most significant driver by far of our long-term debt and our long-term deficits is ever-escalating healthcare costs," US president Barack Obama said, addressing criticism that his plan for universal healthcare coverage was too costly amid ballooning government spending and deficits.



"The bourgeoisie will try to oppose National Health Insurance, because it presents a threat to medical schemes. You dare not stand in front of it, because, if you do, we will bring war unto you and the working class will take action," said Minister of Higher Education and leader of the South African Communist Party, Blade Nzimande, when he promised "war" on medical schemes if they opposed the establishment of national health insurance.

ASPEN PHARMACARE WOULD ADD

at least £56 million (R721m) more to its turnover following its acquisition of eight specialist drugs from GlaxoSmithKline (GSK), it announced. This amounts to the money the drugs generated for GSK in the year to December. The eight products include Alkeran, Leukeran and Purinethol, which are chemotherapy drugs used to treat cancer. Another is Kemadrin, used to relieve the symptoms of Parkinson's disease. Lanvis and Myleran treat leukemia. Septrin is a broad-spectrum anti-microbial and Trandate is used for high blood pressure. These drugs are going to be sold in worldwide markets, except for Alkeran, which GSK is retaining in the US. The company said it would sell 44% in emerging

markets, 36% in Europe, 8% in Australasia and Japan, and 12% in the US and Canada.

Slindile Khanyile,

Business Report, 14 May 2009

THE GOVERNMENT WILL ASK

academics for more input than in the past few years, the Deputy Minister of Health, Molefi Sefularo, said. "You will not find the shouting down of doctors and scientists who can make a contribution," Sefularo told academics at the University of the Witwatersrand. "We are acutely aware of the divide which arose between the state and civil society during the past few years." Sefularo asked academics who had proposals or ideas which had previously

been rejected by the government to re-raise them with his department.

FORMER HEALTH MINISTER MANTO

Tshabalala-Msimang has accepted an invitation to serve as the guardian of mother and child health in Africa. She is now the African Union Goodwill Ambassador and Champion for the Improvement of Maternal and Child Health in Africa beyond 2015. Tshabalala-Msimang pushed very strongly for a women and child agenda while in the Presidency. Tshabalala-Msimang would in this capacity also be involved in the finalisation of AU documents about reproductive healthcare, women's rights and nutrition.

NURSE YOUR HEART

Nothing But The Truth

Where: Market Theatre

When: Runs until 14 June 2009

At long last, a worthy play rendering a classic South African drama has been achieved in John Kani's three-hander. *Nothing But The Truth* is a symbolic translation of one of the greatest tragedies of post-apartheid SA succeeding where many dramatists have struggled to piece together a great story. Located in Port Elizabeth's New Brighton, this piece of fine art amounts to a brilliant utilisation of theatrical devices to transmute the gold of verbal poetry from one to another art form.

Where previous attempts to make plays from the tragedy of apartheid have generally mired in the heavy going of the blame game and race cards, this play avoids that dangerous pitfall by going to the other extreme and swinging wide of a form of presentation that is physically hitched to the structure of the stage and the personal story of an ordinary man. This ordinary man, an about-to-retire librarian called Siphon Makaya, portrayed by Kani, finally refuses to be ordinary when a politically-connected young lad is favoured for the job he applied for.

By choosing to tell the post-apartheid story through the eyes of an ordinary man, *Nothing*

But The Truth becomes a powerful message easy on the ear. Against the backdrop of the historic Truth and Reconciliation Commission hearings, Makaya is ready to tell the truth to his daughter (Leleti Khumalo) and the niece (Welile Thembe) he has never seen. Tensions abound as he tells the story of political and personal

jealousies, neatly woven into the faithlessness of his wife and the animosities of the past that claimed the life of his only son. In essence, this classic explores the relationship between the 'in-ziles' and exiles post-94 through the destruction of a man's aspirations at the very moment when democracy promises so much.

HASA Verdict: It's a must-see.





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Dr Molefi Sefularo, Deputy Minister of Health; Prof Ralph Kirsch, SAMA President; Dr Sue Armstrong, Gauteng Department of Health; Alex van den Heever, CMS Advisor; and Dr Christopher Malokane, Wits School of Economics and Business.

Invited guests include: Barbara Hogan, Minister of Health; Ravi Naidoo, DBSA; Shadrack Mkhonto, Compensation Commissioner and Barry Childs, Consulting Actuary, Lighthouse Actuarial Consulting.

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Conference Format

DAY ONE

Welcoming and networking dinner.

DAY TWO

■ **Re-imagining the healthcare landscape**
Focus on the state of the economy and future funding of healthcare; The road to healthcare reform; and the impact of COID on the private healthcare sector.

■ **Unlocking the Nursing Conundrum?**
Dr Sue Armstrong and Prof Busi Bhengu discuss challenges posed by shortage of healthcare skills, and legislative changes expected in nursing.

DAY THREE

■ **Towards universal access to quality healthcare**
Andrew Donaldson, DDG Treasury; Roly Buys, Medi-Clinic; Alex van den Heever and Prof Ralph Kirsch discuss Universal Healthcare Insurance – options and obstacles.



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