

HASANA NEWS

Exploring new healthcare frontiers



JULY/AUGUST 2010

EXAMINING THE NATIONAL HEALTH INSURANCE SCHEME

HASANA
Awards of
EXCELLENCE

PMB CODE OF CONDUCT ANNOUNCED

**DON'T DELAY! APPLY FOR DENOSA'S
LEADERSHIP FOR CHANGE PROGRAMME FOR NURSES**

THE ROLE OF THE HOSPITAL ASSOCIATION OF SOUTH AFRICA

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.

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For further information on Hasa, access our website www.hasa.co.za or tel 011 478 0156.





HASA NEWS

House VII, Visioned Office Park,
269 Beyers Naudé Drive, 2195
Northcliff
PO Box 4038, 2118 Cresta
website www.hasa.co.za

EDITOR AND PRODUCTION MANAGER

Lucas Malambe,
Executive Officer:
Corporate Communications

ADVERTISING SALES AND SUBSCRIPTIONS

Dawn Adams, Administration Officer
tel (011) 478 0156,7,8,9
fax (011) 478 0410
email contact@hasanet.co.za

LETTERS TO THE EDITOR/ ARTICLE SUBMISSIONS

tel (011) 478 0156,7,8,9
fax (011) 478 0410
email contact@hasanet.co.za

BOARD OF DIRECTORS

- Mr R Allie,** *Melomed Holdings*
Ms M Da Costa, *Netcare Limited*
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*Ex officio

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RECOGNISING QUALITY HEALTHCARE

Hasa Awards of Excellence

Lucas Malambe, Editor Hasa News

The private hospital industry in South Africa is again and again taking up the responsibility to respond to the growing demand to assist indigent patients with emergency medical and hospital services, irrespective of their ability to pay, demonstrating the sector's commitment to good corporate citizenship. They also respond to the clarion call to work more closely with the public sector to achieve this huge task of accessibility to quality healthcare, and in turn this benevolent task by private hospitals serves to broaden the relevance of private health in this country.

More often than not these twin tasks of good social responsibility and the jerking up of the broader public healthcare sector is demonstrated by the Hasa Awards of Excellence that are an integral part of the annual Ministerial Health Worker Awards of Excellence due to be held on 29 November 2010. The venue will be decided in a few weeks – keep posted.

Hasa encourages members that

have excellent programmes that deserve recognition to send entries for my attention (Malambe@hasanet.co.za).

The Hasa Awards of Excellence are a great opportunity for members to leverage their brand as they are taken seriously by the Minister of Health Dr Pakishe Motsoaledi, the department's Quality and Standards Cluster as well as the multinational Not for Profit Organs that sponsor the event.

A study put together for the 2008 Private Hospital Review revealed that the private hospital sector has committed annual expenditure significantly above R120 million in this area of establishing private-public partnerships and extending healthcare to patients that can't afford treatment.

There are other categories such as hospital's engagement with immediate communities (see next page for all the awards categories).

The logical approach to improving access to hospital services in a country short of capacity is to attract further investment in hospital infrastructure.

Additional reforms would be required to ensure a more efficient health delivering system such as the strengthening of Public-Private Partnerships (PPPs).

The introduction of PPPs has been a significant healthcare reform in SA. Hospital groups have shown that this arrangement can work for the benefit of the poor by accelerating the efficient delivery of healthcare services at affordable rates. These initiatives have also resulted in major infrastructural investments that have brought about positive economic and social benefits. A good example is the 2007 landmark agreement between Netcare, a group of

local business people and the Eastern Cape Department of Health that set in motion the facelift of Settlers Hospital and the re-building of Port Alfred Hospital.

Effective Public-Private Initiatives (PPIs) and PPPs present opportunities to strengthen the entire healthcare system and reduce the fragmentation in healthcare service delivery. In so doing, these partnerships will ensure the efficient utilisation of available resources, the reduction of inequities and improved access to the benefit of all South Africans.

The private hospital sector believes that addressing infrastructural, clinical

and training bottlenecks will be more effectively achieved by expanding existing partnerships. As there is a need to showcase more of these arrangements, the Hasa Awards of Excellence has a category that looks specifically at PPPs that work for all stakeholders but more importantly easing access to quality healthcare to the poor.

Another plus for this year instalment is that the finalists (in all categories) get to exhibit their excellent projects at the gala event. There will be a small charge for exhibition space and this will be communicated to finalists in due course will they be interested in exhibiting.

BACKGROUND TO THE AWARDS

Hasa organise, adjudicate, and present the 10-year old HASA Awards of Excellence. It is always an honour to work with the Minister of Health in honouring the private hospitals as well as the unsung heroes and heroines that excel at excellence. The Association initiated the Hasa Award of Excellence to

recognise the excellent role played by private hospitals to ease access to healthcare, sustain private-public co-operations, improve the quality of care, establish world-class wards, and market this admirable work. These finalists are all evidence of such excellence in going beyond the call of duty in achieving quality healthcare for all.



HASA IS INVITING ALL OF ITS MEMBERS TO SUBMIT ENTRIES WITH REFERENCE TO THE CATEGORIES LISTED BELOW FOR THE HASA AWARDS OF EXCELLENCE:

- **Promoting Equity in Healthcare/ Keeping healthcare affordable**
For projects that go beyond the call of duty to improve access to quality healthcare.
- **Involvement in or Service to Local Community**
For projects that keep a strong presence in their communities, and work with their immediate communities.
- **Public/Private Partnerships**
hospital projects that serve as an example of how the private and public sectors can work together to improve access to quality care
- **Establishing World-class Medical Services or Technology**
This is to recognize hospitals that set up new and innovative devices and ways of improving the quality of medical care and reduces length of stay. Hasa believes SA must be a leader in medical and healthcare innovation.
- **Marketing the Private Hospital Industry**
Projects that market the SA private hospital industry as an institution of high standards, quality and excellence.

I hope this year entries will match the high standards of previous years. Deadline for submissions is of entries remains 07 October 2010.



KEY FEATURES OF THE CURRENT NHI PROPOSAL

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Introduction

In South Africa, the debate surrounding the introduction of a (NHI) has returned to centre stage after recent announcements that such a scheme will soon become a reality. The ANC stated in its 2009 Election Manifesto that the NHI would be one of its key priorities. This was confirmed by President Jacob Zuma in his 2009 State of the Nation address. The idea of a national health insurance system is nothing new and the aim of providing universal coverage is one that characterises the health reforms of many developed and developing countries.

The most important issue from an economic perspective is the cost of such a scheme, especially under an assumption of universal access. Some commentators have already warned that the proposed NHI will be massively expensive or even completely fiscally unaffordable. Clearly, there is a need for proper economic analysis of the costs and benefits of NHI in South Africa.

This note is the first of a series of 'NHI Notes' that will examine these issues in more detail. The series of research notes will deal with some of the important questions that need to be answered

around the viability of a NHI scheme and is aimed at contributing to the debate around costs and optimal design. One of the principal challenges is the lack of transparency in the current process. Originally, the only available documents that provided more detail on the proposed scheme were a (leaked) 200 page ANC document¹, a (leaked) 68 page ANC policy proposal on National Health Insurance² and a 4 page elucidation in ANC Today.³ The first concrete steps towards the establishment of a South African NHI were recently taken with the establishment of a National Health Insurance Advisory Committee.⁴ This committee has the mandate to 'advise the Minister on the development of policy and legislation relating to the introduction of a National Health Insurance System.'⁵ Two expected outcomes of the National Health Insurance Advisory Committee are the finalisation of an implementation plan by June 2010 and the eventual implementation of a full NHI system over a five year period.⁶

The aim of this first NHI Note is to understand in more detail what is currently known about the proposed

1. Here after referred to as 'ANC NHI Task Team (2009) National Health Insurance Plan for South Africa'.
2. ANC (2009) National Health Insurance Policy Proposal, 22 June 2009.
3. National Health Insurance: A unified, equitable and integrated national health system that benefits all South Africans. ANC Today. Volume 9 Number 29, 24 – 30 July 2009.
4. Department of Health (2009) Establishment of the National Health Insurance Advisory Committee. Government Gazette, 11 September 2009.
5. See footnote 4, p.5.
6. See footnote 4, p.8.

NHI. The following promise appears in the ANC Today summary: 'Contribution will be less than what members and their employers currently pay to medical schemes. Certain categories of workers, due to their low income status, will be exempted from the contribution. All these funds would be placed in a single pool that would be available to fund all health care in the public and private health sector under conditions that would apply to all healthcare service providers'. Such a statement means little if the terminology remains undefined and no detail is available.

In this NHI Note, some of the key features of the proposed NHI plan will be unpacked and commented on. Experiences from countries that have implemented similar health insurance systems will be touched upon to provide an idea of the practical implications involved in the implementation of each of the features mentioned. This will provide a platform to understand the implications of the current proposal and the resources required to achieve these goals.

1. Key Features of the Current NHI Proposal

1.1 Publicly Administered and Funded National Health Insurance Authority (NHIA)

The NHI proposal envisages the creation of a single-payer fund by way of a NHIA. This fund will receive funds, pool resources and purchase services for the entire South African population. Funding will be sourced from a combination of employer contributions, employee contributions and existing fiscal funding for healthcare. The employer and employee contributions would require an additional tax for all tax payers and their employers, while the existing fiscal funding for healthcare would continue to

be sourced from government's revenue pool which, in turn, is predominantly funded by income tax contributions. An equal split between employers and employees is envisaged. This planned compulsory employer-employee contribution is currently described in the ANC Today publication as 'modest'. In addition, certain categories of low income workers will be exempted from contributions to the NHIA. The ANC Today⁷ publication also claims that the NHI will require no additional government spending on healthcare as percentage of GDP, through, amongst other things, the savings on administrative costs and the removal of the current tax subsidy for medical schemes.⁸

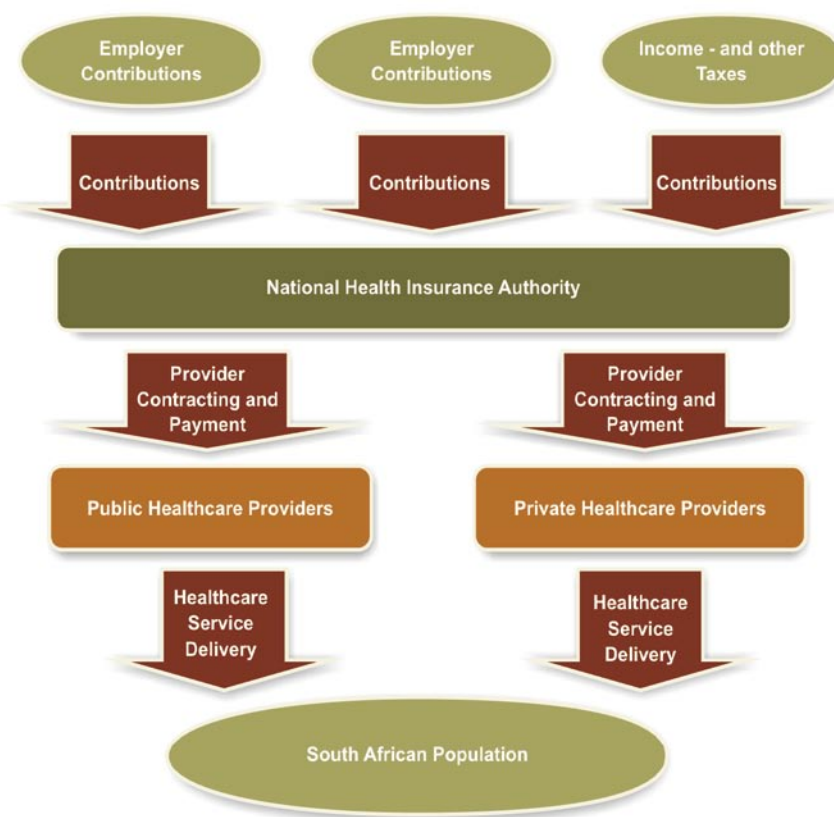
Figure 1 provides a graphical representation of the proposed funding mechanism for the NHI system. Contributions from three sources flow to

the NHIA, where funds are pooled and used to purchase services from both public and private healthcare providers. Purchasing occurs on a contracting basis and will include the services offered by hospitals, clinics and medical practitioners.

Furthermore, the current NHI proposal envisages that the creation of a single funder and purchaser of healthcare will translate into cost savings with regards to both the administration and purchasing of healthcare. Savings in administration costs are believed to occur through the advent of a single purchaser of healthcare as opposed to the current multi-payer (medical scheme) system in South Africa. Other cost savings are envisaged through changes in payment methods from funders to providers.

These include negotiated capitation

Figure 1: Proposed Funding Mechanism for the South African NHI System



Source: Fronlex

7. See footnote 3.

8. 'The current tax deductibility of medical scheme contributions will be removed. This will contribute to increasing tax revenue, which will facilitate the allocation of additional tax funds to the health sector through the NHI Fund'. ANC NHI Task Team (2009:54).

methods for doctors⁹, global budgeting for hospitals and bulk purchasing of drugs and supplies. An important aspect of an NHI that is not given sufficient attention in the NHI documentation to date is the administration cost and, more importantly, the administrative complexity, involved in managing an organisation of the size the NHIA is likely to be. Health economist, Alex van den Heever, puts the potential costs and complexities of such an organisation in context: 'Using the South African Social Security Agency as a model, which has a budget of R4-billion per annum, the NHIA, which proposes to engage in vastly more complex activities, is likely to have a minimum budget of at least R8 billion per annum, which is 400% more than the cost of a current district administration budget.'¹⁰

The introduction of mandatory insurance (as it appears the South African NHI will be) in itself presents implementation challenges. Clear guidelines for enrolment have to be set and authorities should be in a position where they can enforce these enrolment guidelines. This position becomes even more complicated when more than one medical scheme is in existence, either before or after the introduction of NHI. This was also the case in Ghana, where a number of private and commercial schemes remained in operation after the introduction of the Social Health Insurance scheme.¹¹

While Ghanaian authorities set targets for coverage over a 5 to 10 year period, no indication of how enrolment would be enforced was given, leaving the achievement of these targets an open

question. Another potentially problematic area identified in the Ghanaian SHI system was the number of dependents per contributing (working) individual. In Ghana, all dependents are covered even if they are not elderly or children. Fears were raised that this might adversely affect the financial sustainability of the Ghanaian SHI system.¹² All else equal, the total value of contributions from individuals to a SHI system is likely to be equivalent to that of an NHI system in a given country. However, under an NHI system, the number of noncontributing individuals is significantly higher – especially in a country, such as South Africa, with both a high rate of unemployment and a comparatively large informal sector. The implications for the financial sustainability of a NHI authority should not be underestimated.

1.2 Universal Healthcare Coverage and Zero Co-Payments

A central feature of the current NHI proposal is to expand healthcare coverage to the entire South African population. This ties in closely with the premise of social solidarity on which the NHI idea is built, according to which services should be delivered based on need as opposed to the ability to pay. Free access irrespective of the ability to pay naturally requires a great deal of income cross subsidisation between individuals that have the ability to pay for healthcare to those that cannot afford healthcare. This cross subsidisation will be achieved through both the employer/employee contributions and

income taxation – contributions will be skewed to the wealthy, while access to healthcare will be universal.

In this regard, one can take note of the experience of Thailand.¹³ Universal cover in Thailand was achieved through an extended process of consultation from 1993, when it was first seriously debated, to 2001, when it was finally implemented. More importantly, social health reform in Thailand was already quite developed in 1993, when the issue of universal coverage became a priority. The entire process to achieve universal coverage in Thailand took a few decades to become a reality. Indeed, only two countries in the world have achieved universal coverage in less than 40 years from their first legislation on social health. The two countries are Japan (36 years) and South Korea (26 years).¹⁴ Examples of very long implementation periods for universal coverage include Germany (127 years) and Belgium (118 years). The current ANC NHI proposal is the first attempt at legislation on social- or national health insurance in South Africa. Also, the period currently suggested for the implementation of South African NHI is 5 years, an optimistic target by any standard.

Still, the experience of Thailand does indicate some important challenges for South Africa: The first of these was to identify those individuals that needed to be insured and then to put the systems in place to register all covered individuals.

Thailand had to cover a total of

9. Negotiated capitation refers to a situation where medical professionals are not paid on a fee for service basis as is currently the case in the majority of the South African private healthcare market. Rather, a given number of people are assigned to a single health professional or hospital service. The allocation typically occurs through a process of negotiation where remuneration for services to be rendered is agreed.

10. Van den Heever, A. (2009) Killing a Sick Patient: Will National Insurance Heal our Health System? SA Labour Bulletin 33 (3).

11. 'Social Health Insurance' (SHI) differs from 'National Health Insurance' (NHI) in that it covers only those individuals (and their dependents) that are employed. These individuals make contributions to the scheme and, in turn, receive benefits. Unemployed (non-contributory) individuals and their dependents are typically not included in a SHI scheme, but may have access to affordable medical services through other government programmes. The level of income cross subsidisation in an SHI scheme is, therefore, likely to be significantly less than under a NHI system.

12. Hsiao, W.C. and Shaw, R.P. (2007) Social Health Insurance for Developing Nations. World Bank Institute. World Bank, Washington D.C.

13. See footnote 12.

14. WHO (2004) Reaching Universal Coverage via Social Health Insurance: Key Design Features in the Transition Period.

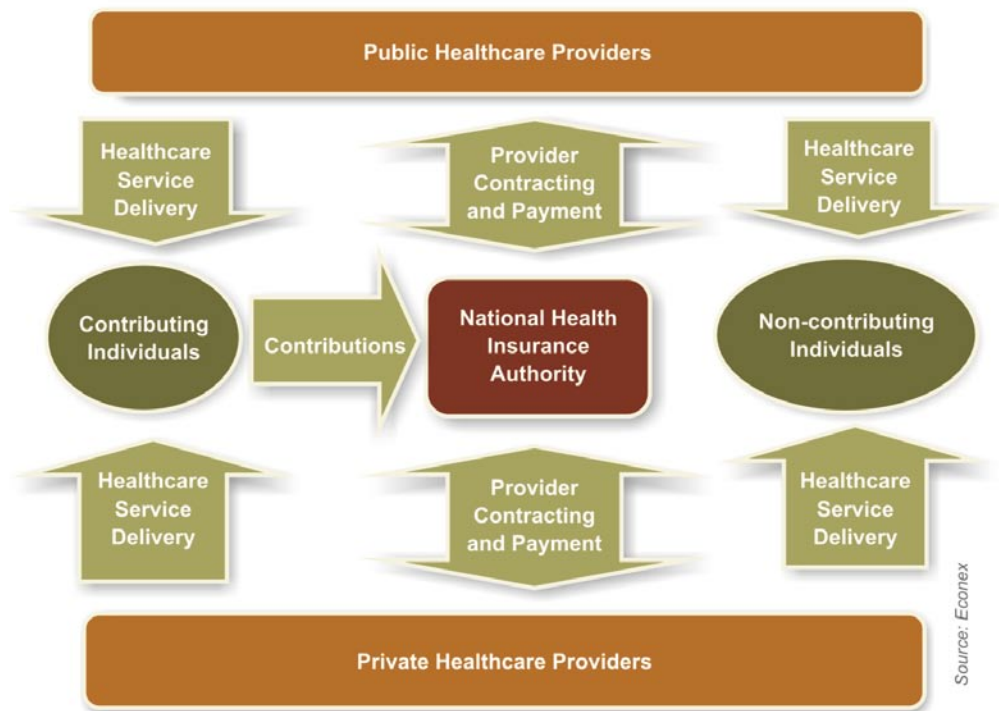
close to 50 million people, a figure comparable to the current South African population. A related problem was the reform of provider payment that accompanied universal coverage. As is the case with the current proposal in South Africa, Thailand decided on a capitation payment mechanism. The capitation payment had to be sufficient to encourage private healthcare providers to sell their services to a NHIA.

Another feature of the current South African NHI proposal is the concept of zero co-payments with all services covered under the benefit package of the NHI.¹⁵ This feature implies that access to healthcare will not require any initial payment with services rendered and will be free to all South Africans at the point of service. This situation can be compared to universal general insurance with no 'excess' payable on claims. Taking current healthcare provision in South Africa as a starting point, a newly introduced comprehensive benefit package with zero co-payments is bound to result in a dramatic increase in the demand for the whole range of medical services. Given the current stock of especially medical professionals, but also other finite resources, it is inevitable that a major increase in the demand for healthcare will require some form of rationing to match demand with supply. The rationing of healthcare within an NHI system is an important aspect in the South African context and will be returned to in a later NHI Note.

1.3 Comprehensive Benefit Package

A comprehensive range of health benefits is suggested, including primary care, inpatient and outpatient care, dental, prescription drugs and supplies.

Figure 2: Service Delivery and Provider Payment in the South African NHI Proposal



Source: Ecorrex

More precisely, the ANC policy proposal on NHI 16 lists the following services as part of the standard NHI benefit package:

- Primary care and preventive services
- Inpatient care
- Outpatient care
- Emergency care
- Prescription drugs
- Appropriate technologies for diagnosis and treatment
- Rehabilitation
- Mental health services
- The full scope of dental services (other than cosmetic dentistry)
- Substance abuse treatment services
- Chiropractic services
- Basic vision care and vision correction (other than laser vision correction for cosmetic purposes)
- Hearing services, including the provision of hearing aids

Such a comprehensive benefit package will be a significant improvement on

what is currently offered in South Africa through the public health system. In Ghana¹⁷, questions have been raised about the costing of their mandatory benefits package and how this will affect the long run financial sustainability of their SHI system. The broad range of services, covering almost all care except certain chronic diseases is seen as too extensive, especially considering the expected increase in utilisation of healthcare services when the system is fully operational. This is also likely to be the case in South Africa if an extensive list of services is offered under an NHI system without full consideration of the financial implications. Referring again to Figure 1, this equates to a larger than expected flow of services from both private and public healthcare providers to the South African public.

15. The only healthcare services that will require an upfront payment will be those that are not covered under the NHI package, currently mostly cosmetic procedures.

16. See footnote 2.

17. See footnote 12.

1.4 Publicly and Privately Delivered Healthcare

Healthcare services will be delivered by both private and public healthcare providers and funded by the NHIA. All service providers will have to be accredited by the NHIA, based on predetermined criteria. This service delivery model is shown in Figure 2: Private and public healthcare providers (including facilities and medical professionals) are contracted by the NHIA. In turn, contracted healthcare providers render their services to both contributing and non-contributory households, based on the principal of universal access on a capitation basis. Contributions are made to the NHIA according to the various channels shown in Figure 1 (employer contributions, employee contributions and other government income).

An important point in this regard is that private healthcare providers cannot be mandated to sell their services to an NHIA. As was mentioned earlier in the case of Thailand, the level of capitation remuneration under an NHI system has to be sufficient to convince private healthcare providers to contract with the NHIA and provide good quality healthcare at the agreed upon capitation price. There will also be no differentiation in the price paid to private and public healthcare providers, implying that the market price will have to converge to the price level needed to attract the services of private healthcare providers. At the same time, the level of remuneration has to be affordable enough to make the NHIA financially sustainable. Balancing the financial sustainability of an NHIA with the ability to contract quality healthcare services from private healthcare providers is a difficult task at the best of times.

In the South African context, the above mentioned task can be considered even greater due to two major contributing factors. Both of these can be explained by way of Figure 2: Firstly, the supply of quality healthcare from public healthcare providers is quite limited and the NHIA

will have to acquire a substantial portion of services from private healthcare providers. As such, remuneration will have to be set sufficiently high to induce these providers to sell their services to the NHIA. This factor will determine the private-public mix of provider contractor and payment shown in Figure 2 and any corresponding flow of services from healthcare providers to the South African public. The second major factor that will come into play in the South African context is the size of the 'contributing individuals' pool compared to the pool of 'non-contributing individuals'. If the aggregate demand for healthcare services is substantially more than contribution flows to the NHIA, this will place increased pressure on the financial sustainability of the NHIA in the absence of very large transfers from other government resources.

the creation of a publically funded and administered National Health Insurance Authority (NHIA); extending cover universally; the provision of a comprehensive benefit package; and the use of a combination of public and private healthcare providers to deliver the before mentioned services. Apart from describing the details of each of these concepts, a variety of country comparisons were employed to illustrate the practicalities of implementing the features in question. It was shown that while many of the current suggestions for the South African NHI are based on admirable principles such as social solidarity, the actual implementation involves a number of complicating factors. Further notes in the Econex NHI Note series will expand on some of the issues identified in the current note as well as other important questions relating to the NHI proposal. The series will culminate with a number of costing scenarios required for a comprehensive NHI system in South Africa. ■

2. Conclusion

This NHI Note provided a brief overview of some of the key features of the South African NHI proposal that have been made public thus far. These include

HEALTH AWARENESS

Calendar 2010

SEPTEMBER


Albinism Awareness Month

National Heart Awareness Month

Women's Health - Cervical Cancer Awareness Month

Muscular Dystrophy Awareness Month

1-7 Pharmacy Week	21 World Alzheimer's Day
1-7 Back Week	24-30 World Retina Week
1-5 Deaf Awareness Week	26-30 Older Persons Awareness Week
9 International Foetal Alcohol Syndrome Day	30 World Heart Day
1-8 Kidney Awareness Week	
15-19 Stroke Week	



ANGER AT NHI SECRECY

SAPA, 1 August 201

Government should break the secrecy over the national health insurance (NHI) and give grassroots stakeholders a say in policy formation, academics and activists said at a seminar on the proposed system over the weekend. Damaris Kiewiets from the Cape Metro Health Forum said that there was no public engagement in this process, and the government had removed itself from public participation in healthcare. She argued that district health committees had to demand to be funded properly and to be made part of the process because their members truly understood the healthcare crisis. The Treatment Action Campaign said it had no idea "what this NHI looks like" and believed government should be confronted with a clear set of demands from people in the field and the public.

Chief among these, TAC representative Lydia Cairncross said, was that the NHI should create a single, free healthcare system that distanced itself from private healthcare. She said the state should stop subsidising the private system by immediately suspending the tax

exemption for medical aid contributions, which cost the Treasury between R10bn and R15bn a year. The one-day seminar, held at the University of Cape Town, heard a range of views on the future of the private system, ranging from angry calls to nationalise it to a more moderate stance put forward by Cosatu that eventually public and private systems should merge.

The labour federation's Western Cape secretary general Tony Ehrenreich said there should be one healthcare system for all our people. He said that if the level of service in the public sector was what it should be, then there would be no need for a private sector based on what was seen as profit motivation. He agreed that the tax exemption was "a prejudice to the public purse" but said it was not an answer to dismantle the private health system in the absence of a viable alternative.

David Sanders, the director of the School of Public Health at the University of the Western Cape, said South Africans lived with "a myth that the private health system is great". In fact it was inefficient and overpriced and often left medical aid subscribers to pay out of their own

pocket as their benefits dried up. He also voiced concerns about the tax exemption, arguing that there was perception that only the relatively wealthy were taxed while in fact the poor carried a proportionately unfair tax burden because of value added tax. Sanders said the country's health crisis would only be resolved if there was a strong social movement informing the government of people's needs and holding it to account. Sanders said he believed the State's plans around NHI were in very early planning stages and probably shrouded in secrecy as a result of fears that leaks would prompt doctors to leave the country. The policy is in the hands of the inter-ministerial committee on national health insurance, from where it will go to Cabinet. Ehrenreich said Cosatu felt sidelined from the policy discussions and planned to raise the issue with government. He said it was of great concern that there was a lot of silence around the NHI and consultation had been inadequate from the side of government. ■

Payment and integration pains diagnosed for NHI

SLINDILE KHANYILE:
Business Report, 30 July 2010

Integrating the public and private health sectors in order to implement the proposed national health insurance (NHI) could be fraught with difficulties and might prove difficult in practice, according to a research report from Econex. The report specifically looks at the challenges of combining the two systems, as would be required for uniform contracting in an NHI-type system. The study says while primary

healthcare will be strengthened due to the approach suggested by the model, it could also result in higher detection rates, thus increasing the number of secondary and tertiary care visits. The report says the private sector currently provides mostly curative care while the primary healthcare model is, by nature, more preventative. It says that while the nation will benefit from such an approach, the overall costs may not necessarily come down. Mariné Erasmus, an economist at Econex, said the costs would rise in the short- to medium-term because the

system would draw in more people, as the service would be free. She said the cost could decrease in the long-term. The report highlights the differences between the public and the private sectors, particularly in the way service is provided, and the different payment models. Currently, private doctors are mainly paid on a fee-for-service basis by medical aid schemes and are mostly not employed by the private hospitals. There are also a number of cash practices with patients paying out of pocket. It is envisaged that

under a proposed NHI system there will be no cash payments, as there will be no charges at the point of service. Erasmus said that doctors in the private and the public sector were not paid in the same way, and how to incentivise doctors under the NHI would have to be addressed. She added that at the moment, people with medical aid had a choice and could walk into any doctor or specialist's room but, under the NHI, the chances of walking into any (private or public) doctor's room were slim. She said it would be quite impossible to give everyone a free

choice. Another challenge would be that of capacity because unrestricted access to any provider of choice, as suggested in the NHI proposal, appeared to be based on a widely held assumption that private providers were able to accommodate many more patients than they currently do. There are 122 000 hospital beds in South Africa. The report said that one hundred percent occupancy was neither practical nor possible. High occupancy rates (over 80 percent) placed strain on the hospital support services, increased pressure on nursing procedures and

patient care, increase the risk of adverse events and also presented challenges for infection control. The research said very few providers would contract with the NHI for anything less than what they were currently charging, and added that some doctors and specialists may simply leave the country. Norman Mabasa, the chairman of the SA Medical Association, said Econex's analysis was correct, but the issues were not insurmountable if the NHI was phased in slowly. ■

COUNCIL FOR MEDICAL SCHEMES ANNOUNCES PMB CODE OF CONDUCT

COUNCIL FOR MEDICAL SCHEMES Circular: 3 August 2010

The industry task team on prescribed minimum benefits (PMBs), which was established in May 2010, has concluded the first phase of its work. Members of the task team have agreed to a code of conduct which will guide stakeholders in an attempt to achieve full compliance with the PMB regulations prescribed in the Medical Schemes Act (Act 131 of 1998). The code of conduct includes guidance on:

- access to information on PMBs, including the use of designated service providers (DSPs), the requirements on marketing information of schemes, and desired educational efforts by stakeholders in respect of PMBs;
- the prescribed level of care for PMB conditions;
- access to alternative interventions where prescribed interventions, scheme protocols, or formularies are inadequate or may cause harm;
- conduct required to accurately identify PMB conditions; and
- administrative processes such as pre-registration, pre-authorisation,

and mechanisms required to deal with disputes in respect of PMBs.

The document also stipulates additional work which needs to be done, including a process leading to the development of communication guidelines, the development of a process for the submission of discharge summaries, interaction with the national task team on ICD-10 (International Classification of Diseases - 10th Revision) on the training of health professionals, the determination of a "reasonable" co-payment in respect of voluntary use of non-DSP facilities, consultation on the use of co-payments from medical savings accounts, and a CMS-lead process for the development of benefit definitions. Progress on these will be communicated soon. The document furthermore indicates that a strategic solution for the "payment in full" provisions in regulation 8 of the Medical Schemes Act is still being sought. Similarly, the impact of the High Court ruling on the Reference Price List (RPL) made on 28 July 2010 is being considered. All medical scheme and administrator representatives on the PMB task team could not reach

consensus on whether the Diagnosis and Treatment Pairs (DTPs) (ie some 270 diseases included in the PMB package) contain chronic elements. But rulings by the Appeals Committee of Council make it clear that benefits related to the chronic elements of DTP conditions are included in PMBs. Representatives from consumer groups and beneficiaries of medical schemes argued that the level of care in the benefit definitions should not refer to the level of care in the public sector as the desired standard for PMBs. To conclude the first phase of the task team's work, the task team members representing medical schemes and administrators, will ask their constituency schemes and administrators to formally agree to abide by the code, and the healthcare provider representatives will interact with their respective representative organisations.

A copy of the Code of Conduct is available: http://www.medicalschemes.com/publications/ZipPublications/Guidelines%20and%20Manuals/CodeOfConduct_20100803.pdf ■

COURT THROWS OUT GUIDELINE TARIFFS FOR MEDICAL SCHEME RATES

LAURA DU PREEZ: Personal Finance, 31 July 2010



THE MAIN CONCERN ABOUT PRIVATE HEALTHCARE TARIFFS, HE SAID, WAS NOT THE ABSENCE OF THE RPL BUT THE ABSENCE OF A LEGISLATED FRAMEWORK THAT ALLOWED FOR MULTILATERAL NEGOTIATIONS ON TARIFFS.

The guideline tariffs used by medical schemes to determine the rate at which they will reimburse healthcare providers were declared null and void this week, after a judge found the process by which the rates were determined to be unfair, unlawful, unreasonable and irrational. The judge said the process had resulted in tariffs that were “unreasonably low” - one of the reasons cited for the exodus of doctors from this country. The judgment by Acting Judge Piet Ebersohn in the case between a number of healthcare provider groups and the Department of Health in the North Gauteng (Pretoria) High Court has created a huge gap that has the department, the medical scheme regulator, schemes and healthcare providers scratching their heads.

Many medical schemes use the Reference Price List (RPL) as the basis for their benefits, and the setting aside of the RPL could affect their rules that relate to the payment of claims. The Department of Health, which came in for harsh criticism from Ebersohn for the way it handled the publication of the RPL, said through its spokesperson, Fidel Hadebe, that it was not in a position to comment on the matter until it had fully studied the judgment and what it meant for the department.

Dr Monwabisi Gantsho, the Registrar of Medical Schemes, said the Council for Medical Schemes was not responsible for the RPL but believes it was important to ensure that there was no void. Gantsho is of the view that the removal of the RPL will not impact on medical schemes’

existing rules. The main concern about private healthcare tariffs, he said, was not the absence of the RPL but the absence of a legislated framework that allowed for multilateral negotiations on tariffs. He said a range of options was being considered, and he would advise Dr Aaron Motsoaledi, the Minister of Health, accordingly. The judge set aside the regulations, promulgated by the Department of Health under the National Health Act, which outlined how the department would obtain information and determine the RPL. After setting aside the regulations, he said that the 2008 and 2009 RPLs, which were published in terms of these regulations, also had to be set aside with retrospective effect.

Ebersohn ordered the department to pay not only the legal costs of the providers that took the matter to court but also the costs, including professional fees and meeting costs incurred in preparing submissions made to the department during the flawed RPL process. The costs order is likely to run into many millions of rands. The court challenge was brought by the South African Private Practitioners’ Forum (SAPPF), 20 other medical professions’ associations, the Hospital Association of South Africa (Hasa), and emergency services providers ER24 and Netcare 911.

Dr Chris Archer, the Chief Executive Officer of the SAPPF, said his organisation’s key message now was one of reconciliation with the Department of Health. Archer said

a new methodology for determining guideline tariffs, which would allow practitioners to earn a reasonable salary and make a reasonable return on the investments they had made into their practices, needed to be developed to stop doctors leaving the country. He said practitioners would be unable to implement the required much higher charges immediately, because this would bankrupt the funding industry, but a process that acknowledged the problems needed to be found.

In his judgment, Ebersohn said “the fact that the 2009 RPL reflected rates that were unreasonably low meant that private healthcare providers would continue to struggle to cover their costs (let alone make a reasonable return on investment). Ultimately, there was the real risk that the effect of the RPL decision would play out on patients, who might face the burden of a declining number of doctors within the country and who might be confronted with general and specialist practitioners who, in an attempt to make ends meet, would be forced to focus on a high-volume turnover of patients at the expense of the quality provision of medical services”. Heidi Kruger, head of communications manager for the Board of Healthcare Funders (BHF) said the BHF was waiting for a legal opinion on the implications of the judgment for schemes. She said the judgment paved the way for the Minister of Health to set up a more robust process to determine guideline tariffs. Kurt Worrall-Clare, the Chief Executive of Hasa, said a new system of determining benchmark tariffs that was mindful of the differences between the various providers in the healthcare sector needed to be developed, and the Hospital Association was willing to discuss this with the Department of Health. Martin Versveld, a partner at law firm Webber Wentzel, which

represented the SAPPF in the case, said schemes were likely to have to change references to the RPL in their rules when they submitted their rule changes for 2011 in the next few months. He said schemes might have to look at basing their benefits on the tariffs set by the Health Professions Council of South Africa (HPCSA). The HPCSA sets the highest rates doctors may ethically charge without obtaining patients' informed consent. Typically, the HPCSA's tariffs were three times the RPL tariffs.

The RPL that forms the basis of many medical scheme benefits was not only drawn up in terms of invalid regulations but the process failed the tests of legality, fairness, reasonableness and rationality, Judge Piet Ebersohn said in his judgment in the case against the Department of Health. Much of the court challenge hinged on the practice cost studies that healthcare providers submitted to the department to assist it to determine the cost of private healthcare services. The department dismissed most of these studies, claiming they did not meet the required sample sizes or they used unacceptable costing or coding methodologies. The judge made the following points in his ruling:

- The Department of Health was, in terms of the National Health Act, supposed to consult with the National Health Council before promulgating the RPL regulations. The department had failed to provide any evidence of these consultations.
- The then Minister of Health, Manto Tshabalala-Msimang, delegated to Thami Mseleku, her then director-general, the power to determine the process of deciding the RPL, and this was impermissible.
- Mseleku decided on the methodology that should be used to determine the costs of healthcare services. He then admitted that this methodology was ill-suited to determining costs for providers such as hospitals and emergency services but failed to deal

properly with proposed alternative methodologies. The publication of a methodology that he knew was ill-suited was “irrational, unreasonable, and arbitrary”.

- Mseleku called on stakeholders to provide alternative methodologies, but he did not have the power to deviate from the methodology he set.
- Individuals were prevented from making submissions, and only associations or professional councils that represented 95 percent or more of the relevant medical discipline were allowed to submit data. This excluded the Hospital Association of South Africa, the two emergency services providers and most of the groups that represented various medical professions from submitting data to the department, which was “very unreasonable, irregular and nonsensical”.
- The department failed to provide reasons for rejecting many of the practice cost studies. This was “manifestly and singularly unhelpful”.
- The draft 2009 RPL was published before the department had even started to verify any of the few submissions it had accepted.
- Changes to the tariff structure proposed by a number of medical disciplines were not implemented in the 2009 RPL, whereas those for one discipline were accepted.

Ebersohn said it was incumbent on the Department of Health to produce “an effective RPL which set rates at an appropriate, reasonable level that was grounded in the reality of the costs of operating private medical practices. He said that regrettably, this did not occur, and the 2009 RPL fell well short of the statutory requirement. ■

OFFICIALS TO FOCUS ON HEALTH BUDGETS

Top health and Treasury officials are set to sign an agreement to improve the financial management of provincial health departments, according to health director-general Precious Matsoso. It is an important step towards tackling deep-seated weaknesses plaguing provincial health departments. The auditor-general has repeatedly expressed concern over the national department's failure to hold provinces to account over spending irregularities, particularly conditional grants. The issue has also irked Parliament's standing committee on public accounts (Scopa). In March, Scopa interrogated the then-acting health director-general Kamy Chetty over the errors and inconsistencies riddling her department's annual report for 2008-09, which had received a qualified audit for the sixth year in a row.

Yesterday, Scopa turned the spotlight on Matsoso, who has been in the job for a mere six weeks, interrogating her on her plans to improve the department's capacity to monitor the provinces' management of conditional grants. She said an agreement was to be

signed by the National Health Council, Treasury, MECs and Finance Minister Pravin Gordhan, spelling out plans to improve financial management. Conditional grants are earmarked for specific programmes, and for this fiscal year those allocated by the Treasury to health totaled almost R20bn. They include: HIV/AIDS (R6bn); hospital revitalisation (R4bn); forensic pathology services (R557m); health professions training and development (R1,87bn); and national tertiary services (R7,4bn). Matsoso told the committee that work was under way to assess the weaknesses in the department's management of conditional grants, starting with the Hospital Revitalisation Grant, which provides funds to projects to upgrade hospital infrastructure. Treasury spokeswoman Kershia Singh said provinces had spent 20,8%, or R836m, of the hospital grant by the end of the first quarter, which ended on June 30.

Tamar Kahn: Business Day, 4 August 2010

SHORTAGE OF RURAL DOCTORS CRITICAL

South Africa's critical shortage of doctors and nurses is getting worse as provincial

health departments report that it is almost impossible to recruit doctors for rural areas. The most recent statistics revealed in parliament show that the country needs an additional 46 000 nurses and 12 500 doctors to treat millions of state patients. Eastern Cape health spokesman Sizwe Kupelo said the problem was particularly acute in his province. He said it was difficult to attract and recruit and retain them, adding that doctors did not want to live in rural areas. Kupelo said Eastern Cape had tried to alleviate the problem by offering conditional bursaries to students prepared to work in rural hospitals once they qualified. In 2007, R45-million was spent on bursaries for 473 students. This was increased to R98-million the following year. But 89 of the students had not fulfilled their obligations, which included working in the province for the same number of years that their studies had been paid for. He warned that his department was going to "catch them" as part of its "Operation Siyamlanda" and force them to repay their bursaries. The department has traced 29 defaulting bursars.

KwaZulu-Natal health spokesman Chris Maxon agreed that it was difficult to lure

EARLY ART CAN SAVE LIVES OF HIV KIDS

ZINHLA MAPUMULO:
Sowetan, 3 August 2010

A South African study has found that treating HIV-infected infants with antiretroviral therapy soon after birth, rather than waiting until they get sick, leads to improved survival rates. The study found that giving ART to HIV-infected infants from the age of seven weeks made them four times less likely to die in the next 48 weeks, compared with postponing ART until signs of illness or a weakened immune system appeared. These findings come from the Children with HIV Antiretroviral Therapy (CHER) trial. Director of the National Institute of Allergy and Infectious Diseases Anthony Fauci said that HIV devastated the nascent immune systems of infants very quickly, yet too many HIV-infected infants did not get tested for the virus, got tested too late or got tested but lacked access to life saving antiretroviral drugs. He said the results of CHER were a clarion call to scale up widespread early HIV testing of at-risk infants



and to make ART immediately accessible to all infants who tested positive. In South Africa 59 000 babies were born HIV-positive last year. The number of children on ARV therapy now stands at 103 000. Principal CHER investigator Gesine Meyer-Rath said during the 18th Aids conference, that the study showed that starting antiretroviral treatment in asymptomatic HIV-infected infants with a CD4 percentage of less than 25, at a median age of seven weeks, reduced the death rate from 16 to four percent compared with those whose treatment was delayed. This,

she said, indicated a 76 percent reduction in infant deaths in the immediate-treatment arm. Those with delayed treatment showed a rapid disease progression and sudden death, she said. The results of the study have been welcomed by many. As a result, the World Health Organisation (WHO) is to recommend immediate treatment of all HIV-infected children under the age of two regardless of their CD4 count or disease stage. But, not many countries will afford to do due to the cost of pediatric ARV drugs. Meyer-Rath was optimistic that South Africa could afford to treat babies from seven weeks.

She said that early treatment during the first year of life not only improved infant survival but provided significant cost savings. Infants who were treated early were less likely to be hospitalised than those who got delayed treatment. The money used to treat and care for them while waiting to be started on ART could be used to buy drugs, she said. The government has adopted the recommend early paediatric treatment in its new guidelines for HIV treatment.

doctors into state employment. Most rural hospitals in his province were staffed by doctors from Britain who “come to South Africa to learn and be exposed to a variety of things”. But they would eventually go home, he said. Saul Karnik, chief executive of non-profit organisation Africa Health Placements, said his organisation had placed 1 700 health workers in state jobs in the past five years. Half of them were foreigners, mainly from the UK, the US and Europe. The national Department of Health has acknowledged the “ongoing” shortage of medical professionals. Fidel Hadebe, spokesman for Health Minister Aaron Motsoaledi, said South Africa not producing enough doctors. Hadebe said Motsoaledi was in “ongoing discussions” with Higher Education Minister Blade Nzimande, and had met the deans of university medical schools to discuss the problem.

Harriet McLea: The Times, 6 August 2010

THE GAUTENG PROVINCIAL GOVERNMENT

has made an about-turn over whether it has cancelled a controversial multi-million-rand tender for an aborted health information systems for the province's hospitals. Gauteng Health MEC Qedani Mahlangu said in reply to the provincial legislature that the contract to supply smart cards had been cancelled. This was later contradicted by her spokesman, Simon Zwane. Mahlangu had asked the Special Investigations Unit to investigate the R590 million contract awarded to the Baoki Consortium in 2008 to supply an electronic health record system that would be rolled out to 37 hospitals and 400 clinics in the province. In her response to DA member of the provincial legislature Jack Bloom, Mahlangu had said Baoki had already been paid R400m for a project that had failed. The department was negotiating with sub-contractors who had lost out because of the cancelled deal, some of which were claiming millions of rands for services rendered.

Zwane said the department was in negotiations with Baoki regarding all aspects of the contract. He said it had not been cancelled lawyers were looking into it. One of the claimants was Sekunjalo Health Systems Technology, which had lost out because of the cancelled contract with Amethys, a partner in Baoki. While Sekunjalo officials were prohibited from commenting on the developments because of confidentiality agreements, indications were that the company would turn to the courts for relief. One official said that all contracts entered into were legitimate and properly awarded, and met all procurement requirements.

Bloom said he understood the total amount being claimed was about R1 billion. He said it was a frightful mess for which nobody had yet been held to account, adding that the problem was that sub-contractors probably had a legitimate claim for damages and this would cost the department heavily, impacting negatively on service delivery. Bloom said patients would continue to suffer in long queues because of the delay in getting a decent computerised system. The termination of the Baoki contract came only months after Mahlangu announced that the department would cancel contracts worth more than R3bn. The department cancelled a R273m administrative consulting contract with 3P Consulting last year. The company took the department to the courts and won an order that it be paid R40m for breach of contract and outstanding payments. The department is appealing against the decision.

Eleanor Momberg: The Sunday Independent, 8 August 2010

MEDI-CLINIC'S RIGHTS OFFER

in which it issued 59.3 million new shares at a subscription price of R23 each in order to raise R1.4 billion has been fully subscribed. The private hospital group announced that due to the fact that the rights offer was fully subscribed, after taking into account the excess applications received, the underwriter would not be allocated any rights offer shares. Two months ago, Medi-Clinic said it would use the proceeds from the rights offer to finance growth opportunities in Switzerland. The group said the expansion projects would add 101 beds, which represents a 7.4 percent increase to the existing 1 365 operational beds of the Swiss operations.

Slindile Khanyile: Business Report, 11 August 2010

IT APPEARED TO BE BUSINESS AS USUAL

at Chris Hani Baragwanath Hospital in Johannesburg yesterday, despite the national strike by public servants. Hospital spokesperson Nkosiyethu Mazibuko said only about a hundred support staff such as cleaners and laundry and kitchen staff out of 6 700 staff went on strike. Police were called to stop striking hospital staff from intimidating those who had arrived for work. A spokesperson for Helen Joseph Hospital said operations were running smoothly. In East London patients at some health centres were stranded as nurses abandoned their posts yesterday. Eastern Cape health spokesman Sizwe Kupelo denied that the

strike had any negative impact, saying that there was very minimal disturbance. Meanwhile, in KwaZulu-Natal public service unions have threatened to shut down hospitals and clinics on Thursday. The unions want an 8.6% wage increase, backdated to April 1, and a R1 000 a month housing allowance. The government has offered a 7% increase, a R630 housing allowance and a 1.5% fixed pay progression. Democratic Nursing Organisation of SA (Denosa) deputy provincial chairperson Sibonelo Cele said his union would make sure that hospital and clinic staff took part in the strike. Nurses and doctors are classified as essential and not allowed to take part in strikes but unions argue there has been no agreement on this.

SAPA, 10 August 2010

THE WORLD HEALTH ORGANISATION (WHO)

has declared the swine flu pandemic officially over, months after many national authorities began cancelling vaccine orders and shutting down hotlines. The WHO's director-general, Margaret Chan, said the organisation's emergency committee of top flu experts had advised her that the pandemic had “largely run its course” and the world was no longer in phase six - the highest alert level. The virus had entered the “post-pandemic” phase, meaning its incidence around the world had returned to levels for seasonal influenza. But Chan cautioned against complacency, saying although hospital admissions and deaths had dropped sharply, countries should watch for unusual patterns of infection and mutations that might render vaccines and antiviral drugs ineffective. She urged high-risk groups, such as pregnant women, to continue seeking vaccination. Unusually, swine flu hits young adults harder than the people over-65, who are believed to have some immunity to the A(H1N1) strain. At least 18 449 people have died worldwide since the outbreak began in April last year. The WHO said last week that the true figure was likely to be higher, but its flu chief, Keiji Fukuda, said it would not be known for some months. There have been about 300 lab-confirmed deaths globally in the past two months, and many countries have long since closed the chapter on swine flu. Governments in Europe and North America began dumping vaccines earlier this year after finding most of their stock was expiring. In Germany, authorities are meeting later this week to discuss who is to pick up the bill for the 34 million doses of vaccines that were ordered and mostly not used.

SAPA-AP, 10 August 2010

Denosa Professional Institute turning nurses into leaders



The Leadership for Change Programme



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For more information please visit us on www.denosa.org.za or contact Heather Sam on 012 343 2315 ext 218

