

A Member of AfroCentric Group



Xpert Vol 5. 2011



Xpert

Contents

- 2 A word from André Meyer
- 3 Implantable defibrillators – shocks for hearts and purses
- 7 The effective measurement of health outcomes
- 10 Integrated care – a case study
- 14 Enhancement of a medicine savings model for Medscheme
- 18 A National Health System in SA - Taking stock
- 29 New trends in HIV management
- 32 Editorial Committee



A word from André Meyer



2011 is a year of celebration for Medscheme which marks our 40th anniversary and the achievement of more than three million lives under management - a first in the South African private healthcare industry.

This year also marks the refinement in Medscheme's vision.

Our new vision - Creating a world of sustainable healthcare - is designed to stimulate greater focus within the organisation on developing solutions that contribute towards achieving sustainable healthcare, not only in southern Africa but around the world.

Innovations introduced by Medscheme during the past four decades have been directed at building sustainability - although "sustainability" was not the buzz word it is today. This has been achieved through effective disease prevention and management supplemented by careful management of healthcare costs, without compromising quality of care.

Our ability to demonstrate a consistent average return on investment of 251%* on fees paid for managed care services is testimony to the effectiveness

of Medscheme's approach. These managed care interventions are complemented by a relentless drive for operational efficiency and quality to further minimise cost drivers.

Xpert is put together by Medscheme's specialists in their various fields, and is designed to add value to our business partners by taking an in-depth look at issues that affect our industry. I trust that this, our fifth edition, will be informative and make for interesting, thought-provoking reading.

Sincerely

André Meyer

* Constantly calculated on a large closed medical scheme.

Implantable defibrillators – shocks for hearts and purses



Dr Bettina Taylor, MBChB (UCT), Int.Dip.Res. Eth (UCT/US National Institute of Health)
Advanced Specialist: Health Policy Unit, Medscheme

After starting her career as a clinician, lecturer and researcher in academic practice, Bettina joined Medscheme to pursue her interests in health policy. During this time she has furthered her studies in health economics and bioethics and has served as clinical reviewer for the Medicines Control Council, participated in the design of the LIMS minimum package and is a member of RETAP.

After completing her MBChB, Renee gained valuable experience in various fields of medicine, both in the private and public sectors in South Africa and the UK before getting involved in a research project on behalf of the University of Cape Town. Renee joined Medscheme in 2000 and was involved in a number of managed care disciplines before moving to the Health Policy Unit.



Dr Renee Bischoff, MBChB (UCT)
Senior Medical Advisor: Health Policy Unit, Medscheme

Most trustees of medical schemes are likely to have dealt with ex gratia applications for implantable defibrillators (ICD). These little devices – whose size bears no relation to their price of R120 000 to R180 000 – are known to save lives.

Where individuals experience dangerous ventricular arrhythmias (abnormal rhythms of the main pumping chamber of the heart), or indeed ventricular fibrillation (useless quivering of the heart muscle), ICDs

are programmed to detect these and to emit appropriate electrical discharges aimed at restoring normal rhythm, as well as function. During ventricular fibrillation, the twitching of the heart muscle results in failure to pump blood through the body. Unless an effective rhythm is restored rapidly, the heart will stop altogether (the 'flat-line' scenario on heart monitors). Although a single, heavy blow to the chest may establish an effective heartbeat in an emergency situation in someone who has collapsed as a

result of ventricular fibrillation, the most effective way of achieving the latter is by means of electrical shock waves delivered by defibrillators.

Whereas original external defibrillators were for use by qualified medical staff only, new-generation units are designed for lay people. Typically these are found in more affluent societies in high-traffic public places like airports, shopping malls and universities and are aimed at administration of shocks prior to the arrival of emergency personnel.



For this reason, the risk of death for any individual patient must be reduced significantly as a result of defibrillator implantation.

may thus even occur in the young and fit for no apparent reason.

Who will benefit from an ICD?

For an ICD to be clinically useful, potential benefits must outweigh any risks. Although implantation is generally deemed safe if performed by competent electrophysiologists, major complications can still occur. These include, amongst others, pneumothorax (introduction of air into the space between the lung and the chest wall), infection associated with device implantation, perforation of the heart muscle by the leads necessitating emergency surgery, stroke and heart attack. For this reason, the risk of death for any individual patient must be reduced significantly as a result of defibrillator implantation.

Whilst historically the focus has been on the treatment of patients with documented, symptomatic arrhythmias (so-called 'secondary prevention'), increasingly it is shifting to those at high risk, but with no evidence of rhythm abnormalities ('primary prevention'). Amongst clinicians affiliated with the European Society of Cardiology, which includes local experts, there is agreement

By implanting shock devices (ICDs) directly into patients at increased risk of ventricular fibrillation these days, appropriate electrical impulses are available whenever needed. Battery-powered units inserted just under the skin below the collarbone contain clever computer chips that can interpret cardiac conduction defects via electrode-tipped wires, and instruct associated capacitors to generate the necessary voltage for correction of an abnormal heartbeat. The necessary wires and sensors connected to these units run via the veins into the heart.

What causes ventricular tachyarrhythmia (fast heart beat) and fibrillation?

Rapid ventricular rhythms, including fibrillation, occur most commonly in

diseased hearts. In the majority of patients they are a manifestation of underlying coronary artery disease. Inadequate oxygenation of the heart muscle, as well as scars from previous heart attacks, predispose to abnormal electrical conduction. Any inflammation or weakening of the heart muscle, as well as structural abnormalities, may also be causative. In certain instances, however, ventricular tachycardias and fibrillation occur in apparently healthy hearts. While external factors such as illicit use of drugs like cocaine and methamphetamine, or abnormal blood concentrations of certain electrolytes, may contribute to the problem, no cause can be established in some. Sudden cardiac death as a result of ventricular fibrillation

that patients with varying degrees of moderate to severe symptoms and signs of cardiac failure, but no evidence of abnormal heart rates, should be offered ICDs in this day and age.

Should medical schemes fund ICDs?

Given the high costs associated with the insertion of ICDs, as well as the expenses associated with maintenance and replacement every few years, comprehensive funding by medical schemes is problematic. Congestive cardiac failure – an indication for primary prevention of arrhythmias – is a common diagnosis, especially within schemes with an ageing population.

Based on the number of patients who may qualify for these devices on clinical grounds, together with the high cost of devices and procedures, reimbursement for all clinical indications endorsed by professional societies is unlikely to be deemed affordable by most boards of trustees.

While it is argued by some that these devices should be funded – irrespective of budgetary impacts – as a Prescribed Minimum Benefit (PMB) for all who could reasonably benefit, Medscheme does not concur with such an interpretation.

The only DTP (Diagnosis-Treatment Pair) within the regulations that makes specific reference to cardioversion (which is the process of restoring the heart's normal rhythm by applying a controlled electric shock) is:

903E	Life-threatening cardiac arrhythmias	Medical and surgical management, pacemakers, cardioversion
------	--------------------------------------	--

This means that where an ICD is requested for primary prevention, the diagnostic descriptor of the DTP does not apply, given that a life-threatening arrhythmia has not as yet occurred.

Where inserted as a secondary preventative measure, PMB level of care should be referenced against prevailing public hospital practice. In this regard it should be noted that the Western Cape is the only province that offers comprehensive electrophysiology services, including insertion of implantable defibrillators, in the state sector. For reasons of affordability, though, prophylactic shock boxes are generally only offered to those with symptomatic arrhythmias who have exhausted all other treatment options.

As schemes have heterogeneous demographic profiles, as well as varying financial reserves and distinct political pressures, the leniency of the clinical guidelines within which these devices and their insertion can be funded are likely to differ between schemes and scheme options.

The paradox

Although the main objective of ICDs is to prevent premature death, real-life use in those less than seventy years of age is common. In one study, more than 40% of devices were implanted in this group of patients. If providers and funders are to focus on quality, as well as sustainability of healthcare, such practice should be viewed with circumspection:

In one study, more than 40% of devices were implanted in this group of patients. If providers and funders are to focus on quality, as well as sustainability of healthcare, such practice should be viewed with circumspection.

A meta-analysis of studies investigating effectiveness of ICDs for the primary prevention of sudden cardiac death has concluded that available data do not conclusively show that prophylactic ICD therapy improves survival in elderly patients with severe cardiac failure. Reduced efficacy in older patients may be as a result of a marked increase in death for reasons other than arrhythmias, i.e. any potential survival advantage as a result of the defibrillator may be diluted significantly.

Given shortened survival for reasons other than arrhythmias, cost-effectiveness of the intervention is likely to be reduced in the elderly.

Westernised medicine has in many ways digressed from the concept of holistic patient management. For diverse reasons, care is often focused in a blinkered fashion on longevity, with inadequate consideration for quality of living, as well as dying. Most people – clinicians and non-

clinicians alike – would likely opt for sudden cardiac death if given the choice as to how to die one day. Implantation of defibrillators in those with moderate to severe heart failure reduces the chances thereof.

The question this of course begs is: What is the quality and duration of life in those who survive life-threatening arrhythmias? What is the natural history of the disease in the absence of sudden cardiac death, especially where transplantation is not a consideration and where there are relevant co-morbidities? Are patients provided with all the facts to make truly informed decisions?

If societal resources cannot support funding of ICDs for all patients in whom sudden cardiac death may be reduced, would it be a fair and appropriate strategy to limit access to those with the highest potential number of quality life years to be gained? Some would argue that this is undue discrimination against the elderly.

References:

1. Zipes DP, et al. ACC/AHA/ESC 2006 Guidelines for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death – Executive Summary. A Report of the American College of Cardiology/American Heart Association Task Force and the European Society of Cardiology Committee for Practice Guidelines (Writing Committee to Develop Guidelines for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death) Developed in Collaboration With the European Heart Rhythm Association and the Heart Rhythm Society. *JACC* Vol. 48, No. 5, September 5, 2006:1064 –1108
2. Santangeli P, Di Biase L, Dello Russo A, Casella M, Bartoletti S, Santarelli P et al. Meta-analysis: Age and Effectiveness of Prophylactic Implantable Cardioverter-Defibrillators. *Ann Intern Med*. 2010; 153: 592 – 99



The effective measurement of health outcomes



Professor Praneet Valodia (BPharm, MPharm, PhD)
Advanced Specialist: Health Intelligence Unit, Medscheme

Praneet began his career as a lecturer and researcher in pharmacology before becoming permanently involved in the managed care environment. Over the past 14 years he has held a number of positions at senior and executive level but since joining Medscheme his primary focus has been on research, innovation and scheme reporting within the Medicines and Beneficiary Management area.

Nicole completed her BPharm and MSc (Pharmacy) degrees at Rhodes University. Before joining the Medscheme Health Intelligence Unit in 2009, she worked for the Aid for AIDS Unit. She is currently involved in the Medicines and Beneficiary area with a focus on clinical outcomes reporting.



Nicole Jobanputra (BPharm, MSc (Pharmacy))
Clinical Specialist: Health Intelligence Unit, Medscheme

Medscheme currently offers a number of disease management programmes that support patients in managing a range of conditions including diabetes, asthma, allergy, depression, bipolar mood disorder, hypertension, dyslipidaemia, cardiac failure, osteoporosis and suicide.

Health outcomes are measured to demonstrate the value of these programmes and hence the impact of interventions offered for these programmes. This is often a challenging task as there are many factors that contribute to the effective measurement of health outcomes.

The accuracy of health outcomes measurement depends largely on the

quality of the data collected. A structured questionnaire should be designed with outcomes reporting in mind to allow the collection of data in a specific way. This article will focus on the factors that should be considered when designing a disease management questionnaire and some of the challenges involved with the measurement of health outcomes.

Definition of health outcomes

The term 'health outcomes' has been used loosely and, as a result, there is a great deal of misinterpretation of the definition. For this reason, Medscheme has adopted the definition published by the International Society for Pharmacoeconomics and

Outcomes Research (ISPOR). ISPOR defines 'health outcomes' as "the scientific discipline that evaluates the effect of healthcare interventions on patient-related, if not patient-specific, economic, clinical and humanistic outcomes".

It should be noted that this is a scientific discipline and hence scientific and research principles must apply. The method applied should allow individual patients to be tracked over time and there needs to be a clear understanding of the relationship between the interventions and the outcomes. Any improvements in the clinical outcomes need to be directly attributed to the disease management programme rather than another unrelated intervention.

Design of questionnaires

An important aspect of measuring health outcomes is to obtain reliable data for analysis. This can be performed effectively by using a structured questionnaire which has been developed and validated using scientific principles.

The first step in designing a structured questionnaire for disease management is to outline the process of the interaction with the beneficiary, i.e. how many interactions should be taking place and the duration of each interaction. The interventions performed at each interaction should be carefully considered. This involves ranking the interventions from those with the highest impact

to the lowest for each interaction with the beneficiary. Interventions with the highest impact should be implemented as soon as possible.

The outcome parameters to be measured should be determined at the outset so that the structured questionnaire can be designed in a specific way to facilitate the collection of data accurately.

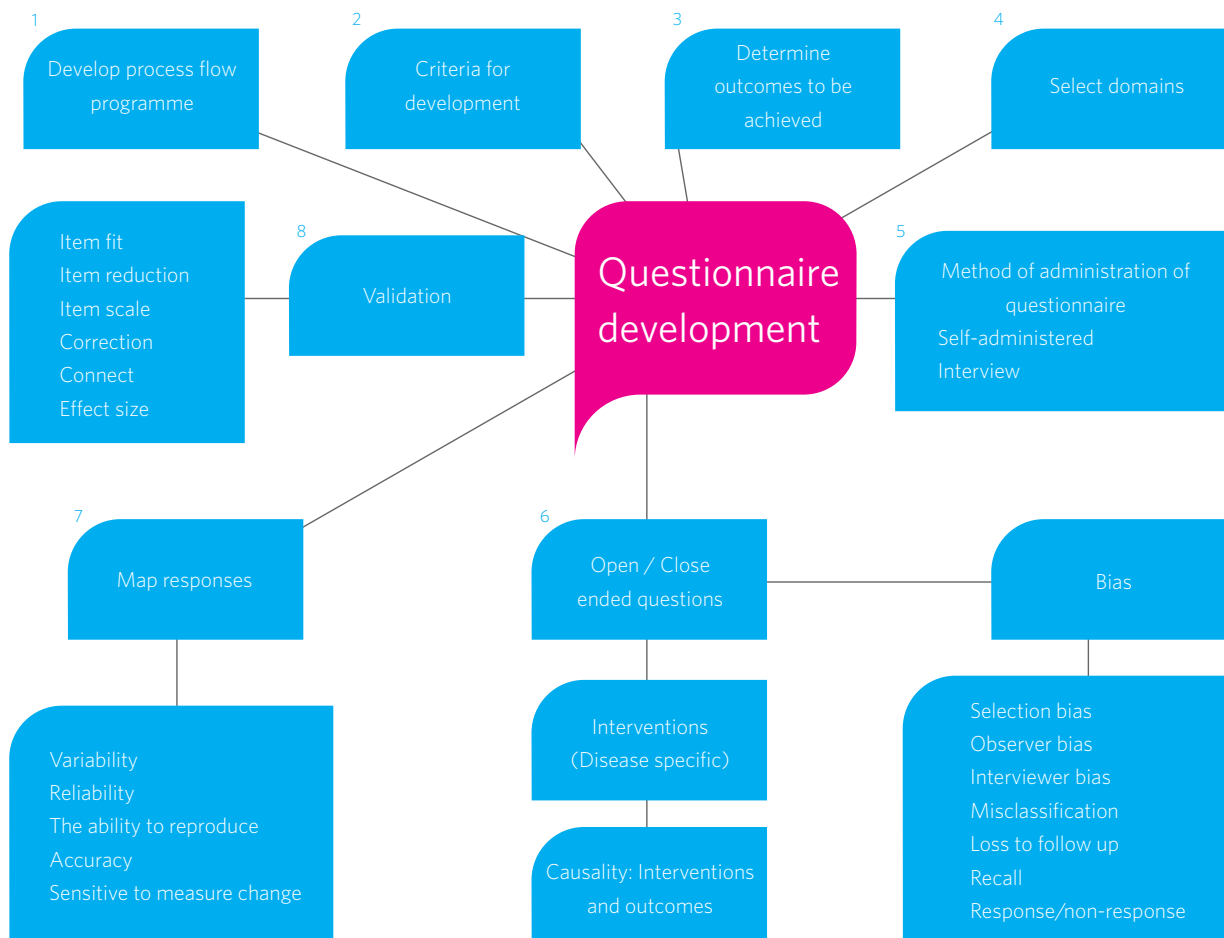
Each question designed (whether open or closed-ended) should be mapped for the following: possible answers, the variation expected in the answers, the intervention performed as a result of each response and the impact of each intervention. Questions that are shown to have a huge variation in response and low impact on an

intervention will be considered for exclusion from the questionnaire.

The questionnaires for the Medscheme disease management programmes are developed in conjunction with the operational staff such as the care managers. Before implementation of a questionnaire an interaction with the beneficiary is role-played by the care managers to ensure an effective design of the questionnaire.

These questionnaires, which form the cornerstone of disease management, are reviewed every six to 12 months.

A schematic representation of the process followed by Medscheme in designing a disease management questionnaire is illustrated below:





South Africa is entering an important and exciting phase of measuring health outcomes. Medscheme has designed beneficiary management questionnaires in line with the health outcomes principles.

Factors affecting health outcomes measurement

Below is a list of some factors that should be taken into account when measuring health outcomes:

- The relationship between the impact of the intervention and outcomes.
- The outcomes should assist with the measurement of the efficiency of the process or the intervention.
- Understand the impact of an intervention relative to the other interventions for the particular programme.
- Ability to aggregate sparse data sets to accommodate for missing data points .
- Scientific planning of the data collection process by using a structured questionnaire.
- The ultimate aim should be the ability to track individual beneficiaries over time in order to measure the individual outcomes.
- Ability to use variable baselines and apply matched control groups to measure outcomes.
- Ability to integrate clinical and claims information.
- Interpret the clinical and statistical significance of the data and the interaction between these.

- Validation of the claim codes, particularly as managed healthcare uses 'real world data' as opposed to data in a well-designed clinical trial.
- Regression to the mean - this phenomenon poses a threat to the validity of the results. This concept suggests that, without the effect of the intervention, members with high costs and utilisation in the baseline year will tend to cost less and use fewer services in the following year (a move toward the mean).

Conclusion

South Africa is entering an important and exciting phase of measuring health outcomes. Medscheme has designed beneficiary management questionnaires in line with the health outcomes principles above. This, in turn, will allow us to demonstrate the value of some of the managed healthcare programmes, particularly disease management programmes.

In addition to the design of questionnaires with a health outcomes focus in mind, the development of IT tools which utilise health intelligence is important.

Integrated care - a case study



Dr Mike Marshall, MBChB
General Manager: Health Providers and
Health Risk Management, Medscheme

Mike graduated from the University of Cape Town Medical School in 1989. He has since gained wide clinical experience both locally and abroad, as well as in the public and private healthcare sectors. Before joining Medscheme in early 2005 he practiced as a general practitioner for seven years. Within Medscheme his work predominantly focuses on healthcare provider relations. He is particularly interested in finding ways to collaborate with healthcare professionals in order to find solutions to the funding challenges that exist within the private healthcare sector.

Previous editions of Xpert have included articles on healthcare professional and beneficiary risk management initiatives. In essence the articles argued that benefit design and rules-based interventions are and will remain important components of a risk management

The medical fund in question is a closed medical fund with approximately 75 000 beneficiaries.


strategy; however, in order to advance to the next level healthcare professional and beneficiary risk management initiatives would need to be implemented to complement current interventions.

Most Medscheme clients have implemented these strategies to a greater or lesser extent. In most cases the healthcare professional and beneficiary risk management interventions are either separate initiatives or only one of the components have been implemented. This article reports on Medscheme's experience with a closed medical fund that has implemented integrated healthcare professional and beneficiary risk management interventions.

Background

The medical fund in question is a closed medical fund with approximately 75 000 beneficiaries. The fund has a contracted network of 1 753 general practitioners (GPs). Mostly





beneficiaries have excellent access to a network GP (98% of members are within 10 km of a network GP). In addition utilisation of the GP network is high with 87% of GP claims originating from a network GP.

The fund actively promotes the use of a network GP through its internal communications.

The role of the GP as the primary care giver and coordinator of secondary care is promoted in the benefit design. Beneficiaries are requested to nominate a GP as their primary care coordinator. Benefits are only available for primary care services from the GP with allowances made for emergencies and out of area visits.

The purpose of this intervention is to facilitate appropriate and coordinated access to specialist care.

In addition, a referral management process is in place whereby beneficiaries in most instances will only get benefits for consulting a specialist out of hospital once they have been referred by their GP. The purpose of this intervention is to facilitate appropriate and coordinated access to specialist care.

It is important to note that the fund offers comprehensive out of hospital benefits to support this approach.

Objectives

The fund's principal objectives are simply to ensure that members have access to quality healthcare whilst ensuring financial sustainability of the scheme and affordable contributions for members. Being a closed medical fund it is intended that this approach will improve "wellness" in the workplace and increase productivity of employees.

The fund hopes to achieve this by facilitating the creation of a supportive environment for best clinical practice to occur. This essentially involves creating a funding environment that attempts to align the healthcare delivery model to:

- A primary preventative care model where beneficiaries have a "medical home".
- Care is determined by a proactive plan to address healthcare needs of the GP's linked beneficiaries whether the GP is visited or not.
- Care is standardised according to evidence-based guidelines.
- Quality and financial outcomes are measured and rapid changes are made to improve outcomes where indicated.
- Care is coordinated by the GP by utilising an appropriate team of healthcare professionals where indicated.
- Tests and adherence to evidence-based guidelines are tracked and there is appropriate follow-up after emergency room and hospital visits.

Components of the integrated care model

The basic components consisting of a contracted network of general practitioners and benefit design has been discussed above. Specifically



the fund benefit structure has been aligned to support the outcomes of this model (value-based benefit design).

A **Clinical Coordination Committee (CCC)** consisting of practicing GPs, a pharmacist, representatives from the fund and Medscheme has been established. This committee:

- Provides clinical oversight especially focusing on clinical guidelines supported by a structured continuing professional development programme.
- Provides strategic input into structuring interventions to achieve outcomes.
- Plays a vital role in improving communication between the fund, network GPs and beneficiaries. These communication channels play an important role in providing

feedback on the impact of any interventions.

The fund uses an **analytical tool (REPI²)** to provide information to individual contracted GPs. This information is based on claims data from beneficiaries attributed to individual contracted GPs. The GPs are provided with a report on the following information on a quarterly basis;

- The financial impact of clinical interventions on their attributed patients including downstream costs.
- Their individual performance against a risk adjusted cost target. Specifically this cost target considers the total cost that the GP is able to reasonably influence (i.e. downstream costs). This is especially relevant given that

specialist referral management is part of this model.

- Their performance against 21 quality targets.
- The performance against cost and quality targets is used to calculate a final score that categorises the GPs into three categories.
 - Category 1 GPs perform better than their target.
 - Category 2 GPs essentially perform to their targets.
 - Category 3 GPs perform worse than their targets.

Coordinated input from the CCC plays an important role in the ongoing development of **REPI²**.

The quality and cost targets have been aligned to the objectives of the integrated care model. As such performance-based reimbursement is part of this initiative. Contracted GPs who meet or outperform their targets are reimbursed at higher consultation fees than those GPs who fail to meet their targets. General practitioners who miss their targets by far are subject to a peer management process. A peer review sub-committee performs this task. The emphasis on the peer management process is for peers to work with the GP to formulate a plan to meet or exceed targets. It is not intended as a punitive process.

The emphasis on the peer management process is for peers to work with the GP to formulate a plan to meet or exceed targets.



In order for the GP to meet quality and cost targets, GPs are empowered with information on their patients. Specifically they are notified of beneficiaries that are at risk of generating high costs going forward. Predictive modelling techniques are used to identify “high risk” beneficiaries.

These beneficiaries are then enrolled onto a structured beneficiary risk management programme. In this programme trained nurses perform structured interventions. Consent is obtained from the beneficiary to share this information with their nominated GP. The GP is notified that their patient has been enrolled and in many cases beneficiaries are referred back to their GP. This approach is intended to empower the GP to proactively intervene on high-risk beneficiaries and in addition the supporting interventions will assist the GP to meet quality and cost targets.

A web-based platform has been developed to facilitate the exchange of information between the network GP and the fund. There is an exchange of clinical information and claims data on the high-risk beneficiaries who have been enrolled onto the beneficiary risk management programme. Specifically this intervention notifies the GP when certain interventions are required on

these high-risk beneficiaries. In addition there is reporting on adherence to evidence-based clinical guidelines and outcomes. The beneficiary is also prompted via sms that certain interventions are required. This innovation is in the pilot phase and is currently active at eight sites.

Mental health and spinal surgery are significant cost drivers in this fund. Mental health and back rehabilitation disease management programmes have been implemented to assist in the management of these beneficiaries. The CCC has actively participated in the design and “marketing” of these programmes to network GPs.

Impact

The integrated care model for this fund is an evolving model. The components discussed above have been implemented over a period of time with most being implemented during 2010.

The referral management process reduced out of hospital specialist utilisation by 20% without an increase in GP utilisation.

The fund also experienced a reduction in hospital utilisation of 3%. This was associated with hospital cost per life per month increase which was below the industry norm for hospital inflation.

Whilst it is difficult to carve out the impact of the beneficiary risk management programme, the impact of this intervention has been studied in the greater Medscheme environment using a control group. This demonstrated a 1,2% savings on total scheme costs with the interventions only being applicable to 3,89% of total membership. Further studies will be done to demonstrate the impact of integrating the beneficiary risk management programme with the GP network as described in this initiative.

The mental health programme is in the process of being implemented but it is still too early to demonstrate any impact.

Spinal fusions have reduced by 14% since the back rehabilitation programme has been implemented as part of the integrated care model.

Conclusion

This is an evolving model and some promising results are already evident. More active involvement of specialists would be essential to grow on the initial successes of this approach. In addition it would be necessary to improve integration of the “traditional” managed care interventions to support this initiative.

Enhancement of a **medicine savings** model for Medscheme



Professor Praneet Valodia
(BPharm, MPharm, PhD)
Advanced Specialist: Health
Intelligence Unit, Medscheme

Praneet began his career as a lecturer and researcher in pharmacology before becoming permanently involved in the managed care environment. Over the past 14 years he has held a number of positions at senior and executive level but since joining Medscheme his primary focus has been on research, innovation and scheme reporting within the Medicines and Beneficiary Management area.



Lourens Wepener (BCom)
Specialist Statistical Analyst: Health
Intelligence Unit, Medscheme

Lourens qualified with a BCom degree majoring in Actuarial Science from the University of Stellenbosch. Before joining Medscheme he was involved with modelling of life and annuity products. Since joining Medscheme he has been involved in the Medicines and Beneficiary area with a focus on calculating medicine savings.

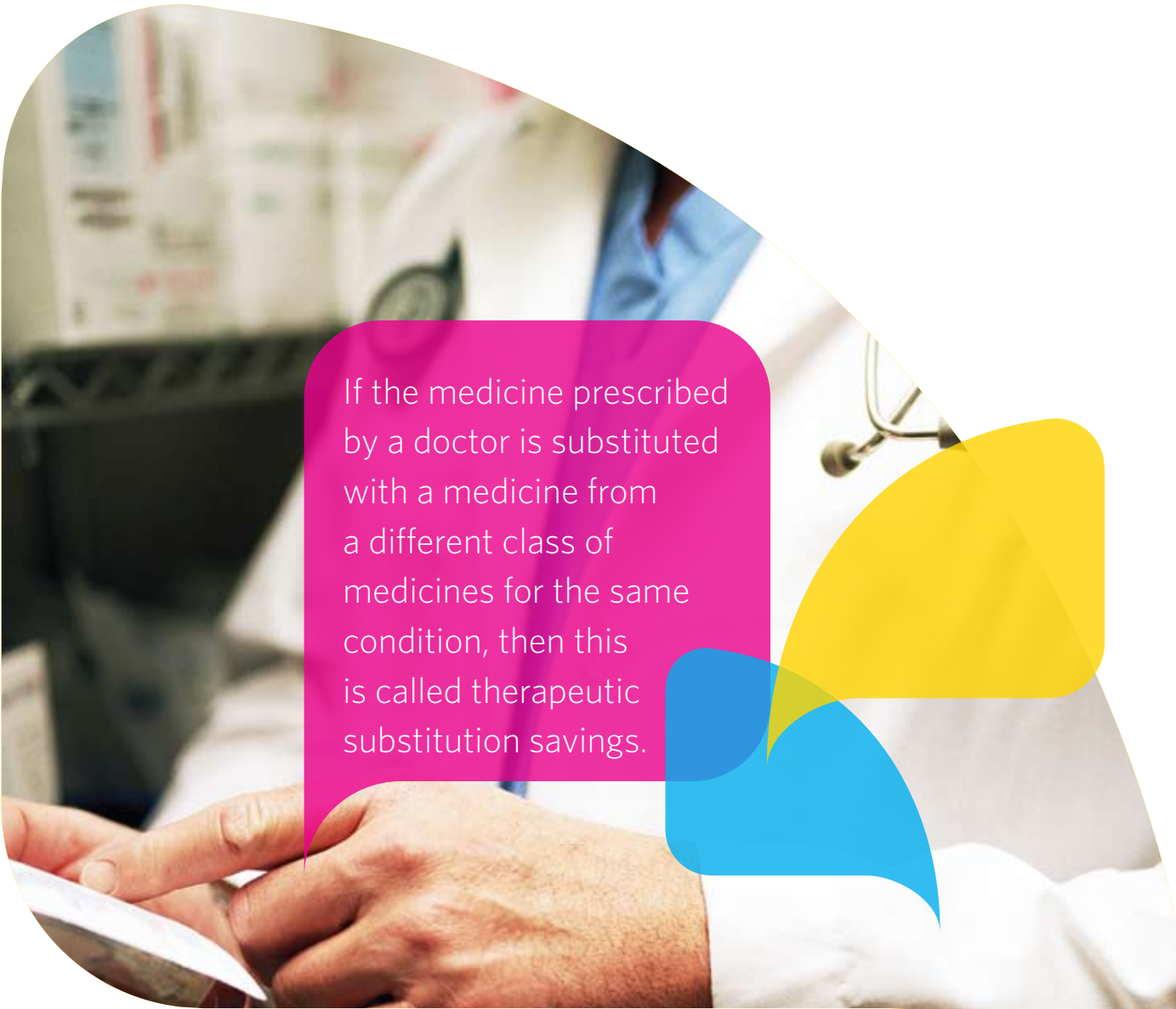
The development of an enhanced medicine savings method was initiated to quantify savings as a result of interventions of the Medicine Management programme. The purpose of this article is to categorise the type of medicine savings, quantify savings that can be expected, and to elucidate on some of the challenges facing such a project.

This article also provides information on how some of these challenges were resolved. This is an ongoing project which requires regular review. Only current interventions are measured and not previous behaviour changes of prescribers as a result of the Medscheme Medicine Management programme. As many schemes have used the Medicine Management programme for some time, the evaluation of savings at this point in time is probably underestimated.

Description of type of savings

Intervention savings

These savings are as a result of an intervention performed by a Drug Utilisation Review (DUR) pharmacist in line with clinical protocols developed by Medscheme. These savings apply to medicines used for chronic conditions.



If the medicine prescribed by a doctor is substituted with a medicine from a different class of medicines for the same condition, then this is called therapeutic substitution savings.

The DUR process involves the following checks:

- Medicine dose.
- Dosing frequency.
- Length of therapy.
- Medicine to medicine interaction.
- Medicine to disease interaction.
- Medicine to gender interaction.
- Medicine to age interaction.
- Safety in pregnancy.
- Adherence to Medscheme clinical protocols.

The most frequent intervention is when a generic medicine is authorised instead of the original medicine applied for by the doctor. This is called generic substitution. A generic medicine has exactly the same active ingredient, strength and dosage form

as the original medicine. Without this intervention the beneficiary may be subjected to a co-payment at the point of dispensing. This is to prevent cost shifting to the beneficiary. The generic medicine will in all probability be much cheaper than the original medicine.

If the medicine prescribed by a doctor is substituted with a medicine from a different class of medicines for the same condition, then this is called therapeutic substitution savings.

The interventions also occur for some of the following reasons:

- The prescribing doctor is unaware that a generic medicine exists or that a less expensive generic

medicine is available. The doctor may also be unaware that a particular medicine is out of stock at the wholesalers.

- A medicine can be intervened on by changing to another medicine with a lower strength. The principle is to authorise the lowest strength of the medicine that will match the clinical picture of the beneficiary. This is helpful in reducing side-effects of a medicine.
- The quantity of medicine authorised is often changed depending on the dose, dosing frequency and duration of treatment. Medicines are also limited to a month's supply at a time.

- Medicines from the same class of medicines may be erroneously prescribed or a second medicine added without terminating the first medicine. This results in a therapeutic duplication of medicines.

Rejection savings

Rejection savings contribute the largest amount towards the overall savings. The medicines are rejected based on the clinical protocols developed by Medscheme. The rejections are performed by DUR pharmacists. These savings apply to medicines used for chronic conditions. The key challenge with this form of savings is to ensure that only true rejections are taken into account in the final calculation.

A common example of this is when an application is received for an authorisation for a lipid lowering medicine. In this case, Medscheme will not authorise a medicine unless a lipogram (total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides) is available for evaluation. In this case, the application is kept on hold and not counted towards rejection savings. Once the laboratory results are obtained, an evaluation is performed by the DUR pharmacist and if the application is in agreement with the clinical protocol, the application is authorised. This is not counted as true rejection savings.

The IT system is able to link the medicine applied for initially with the medicines that have been authorised or rejected within the last two months. This is also done to avoid double counting where the same or similar

medicine is rejected multiple times. If the 'applied for' medicine is changed within the next two months, then this changed medicine will be evaluated. If the initially rejected medicine is now authorised for a cheaper medicine in the same ATC class, then this is counted as an intervention savings. If the item remains rejected (i.e. not authorised within two months) and within the same ATC class, then the rejection is regarded as a true rejection.

Medscheme price list (MPL) savings

The Medscheme Price List (MPL) is a list of medicines developed by Medscheme that are considered cost-effective in the market place. The MPL refers to the maximum price the scheme will pay for a particular product. The products on the MPL have been registered by the Medicines Control Council on the basis of generic equivalence (same ingredient(s), same strength, and same formulation) in comparison to other products. The formulation of products on the MPL may differ (e.g. tablets versus capsules; slow-release versus immediate release, different salts of active ingredients) from the claimed

product. This occurs where one formulation has not shown convincing clinical superiority over another.

The MPL for a medicine is determined by considering all prices within a class of medicine. Medicines affected by the MPL will only be paid for at the price of the medicine on the MPL. In this evaluation all the claims were reprised to quantify savings attributable to MPL only.

Medscheme exclusion list (MEL) savings

The (MEL) is a list of medicines not funded by the medical schemes. The objective is to protect the Acute/Routine Medicine Benefit through the exclusion of certain medicines from payment. It is a list of medicines that does not support the principles of evidence-based medicine.

The MEL is applied at the level of acute medicines when a claim is submitted by a pharmacy and the item is rejected by the Medscheme claims system. The list is updated and communicated to providers on a regular basis.

The IT system is able to link the medicine applied for initially with the medicines that have been authorised or rejected within the last two months. This is also done to avoid double counting where the same or similar medicine is rejected multiple times.

Challenges

It is essential that all initial rejections counted as preliminary savings are indeed true savings. A verification step was conducted by excluding the same or similar items that were initially rejected but subsequently authorised as savings.

The IT system records each application or update of a medicine item in a separate line. These lines had to be linked using special techniques to ensure that all information relating to a particular application or person is linked and interpreted correctly. Whether the savings were classified as interventions or rejections correctly were verified.

A verification step was developed to eliminate capture errors due to medicine quantities.

Calculation of savings

The intervention savings were calculated as the difference between the costs of the initial medicine applied for and the cost of the medicine authorised. If the initially rejected medicines were authorised at a later date then this was recorded not as rejection savings but as intervention savings.

For the rejections, the savings were the cost of the rejected medicines applied for.

The authorisation duration for rejection or intervention savings for chronic medicines was taken into account in calculating the absolute savings. In this case, an adjustment was made to take into account the actual authorisation period or if the authorisation period was longer

than 12 months, the authorisation period was limited to 12 months.

The savings figures were also adjusted for claims compliance of 70%. This adjustment assumed that beneficiaries only claim medicines for 70% of the time from the doctor or pharmacist. The MPL savings were calculated as the difference between the SEP amount including dispensing fee for a specific medicine claim and the MPL amount including dispensing fee. The MEL savings were calculated as the amount charged for a rejected claim with a MEL rejection code.

The savings per scheme varied depending on factors such as the mix of claims, benefit structure and demographics. The weighted average savings per scheme was 10,1% (range 6,7 to 13,9%) of total medicines expenditure.

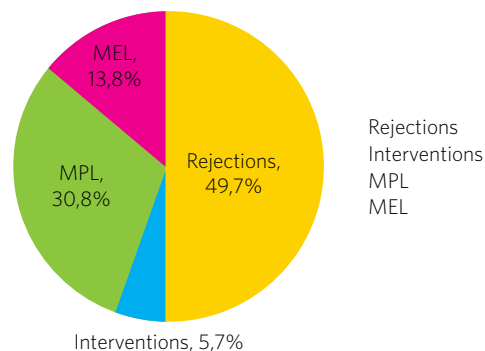
The proportion of savings contributed by the various savings categories for the schemes administered by Medscheme are presented below.

CONCLUDING REMARKS

The Medicine Management programme adds value by significantly producing savings for medical schemes. This article excludes a discussion of savings as a result of interventions on exgratia applications, savings as a result of contracts with designated service providers and medicine formularies. Although a number of different methods to express savings can be debated, only the most common methods have been discussed.

A verification step was developed to eliminate capture errors due to medicine quantities.

Proportion of savings for various categories of savings



A National Health System in SA – Taking stock



Professor Laubi Walters
Deputy Managing Director, Medscheme

Laubi qualified as a medical doctor and also holds a Masters degree in Pharmacological Medicine. He has held several positions in the medical industry including General Practitioner, Professor of Clinical Pharmacology and Director of Primary Healthcare at the Department of Health before he joined Medscheme in 1993. From the outset, Laubi was involved in developing the medicine utilisation review and disease management programmes for Medscheme and is currently Acting Managing Director of Medscheme's managed care business.



Mike Duly CFP
Senior Manager: Branding and
Communications, Medscheme

Mike obtained a dual Fellowship in Healthcare and Employee Benefits from the Financial Planning Institute (FPI) before studying strategic marketing and communications at Wits Business School. He has extensive marketing and communication experience in the healthcare and financial services industries and has been instrumental in implementing Medscheme's communication and branding strategies.





One thing is for certain. An NHI system is in our future and with the imminent publishing of the government's discussion paper we would do well to remind ourselves what is envisaged, where we are in the process and what the discussion paper is likely to contain.

According to information available, South Africa spends 8,7% of its GDP on healthcare, some 84% of which is spent within the private sector. This expenditure is significantly greater than the healthcare spend of any other African country (and indeed more than some countries that are not part of the African continent) and yet our health outcomes are significantly worse than countries spending much less than South Africa on healthcare.

In his Health Budget Vote speech delivered to the National Assembly on 31 May this year, the Minister of Health, Dr Aaron Motsoaledi, put our health system into perspective when he said that the South African healthcare system " ... is at the cross-roads. We may choose the best route or the worst one ever."

The "route" Minister Motsoaledi is referring to is, of course, a National Health Insurance (NHI) system which, depending on whom you listen to, is either the cure for all the ills within the South African healthcare system or an expensive folly we can ill afford.

One thing is for certain. An NHI system is in our future and with the imminent publishing of the government's discussion paper we would do well to remind ourselves what is envisaged, where we are in the process and what the discussion paper is likely to contain.



Compulsory or mandatory financial contributions from both private and public sources are envisaged to ensure that the entire South African population is covered.

NHI benefits for every South African with the public sector being the backbone.

The NHI Task Team has indicated that working people will contribute an additional amount.

What the NHI is

The National Health Insurance model is defined by the National Department of Health as “a mandatory healthcare funding model that provides all citizens with adequate healthcare coverage at an affordable cost through a prepayment funding mechanism.

“This healthcare funding mechanism should provide sufficient financial protection so that no South African household is impoverished because of a need to use health services.”

In essence the proposed South African NHI model comprises mandatory membership to the NHI system which provides a centrally administered basic package of healthcare at the point of use. The NHI Task Team, however, envisions a comprehensive set of NHI benefits for every South African with the public sector being the backbone for providing the healthcare services.

The proposed funding mechanism

The proposed funding mechanism will involve cross-subsidies from the rich to the poor and from the healthy to the less healthy. These cross-subsidies will ensure that individuals contribute to healthcare funding according to their ability to pay and will benefit according to their need for healthcare.

Compulsory or mandatory financial contributions from both private and public sources are envisaged to ensure that the entire South African population is covered.

The financial contributions will be made by employers, employees and those who are self-employed with the government providing for the indigent. The percentage of GDP which will be spent on healthcare will increase substantially from the current level of 8,7%.

The NHI Task Team has indicated that working people will contribute an additional amount of between 3% and 5% of payroll and there will also be increased tax allocations to make NHI affordable.

This, notwithstanding existing taxes already funding billions of rands towards the public health sector.

A discussion document was published for public comment on 17 June 2011 and gives effect to the 2011 Budget tax announcement by the Minister of Finance to reform the current medical deduction allowances by replacing them with medical tax credits.

While this reform will be implemented in phases, it forms part of a comprehensive reform proposal.

The first phase of this reform is set out in the legislative amendments of the 2011 Draft Taxation Laws Amendment Bill (TLAB) published on 2 June 2011 in respect of the proposals relating to Medical Scheme Contributions which are intended to take effect on 1 March 2012.

The proposals comprise:

- A medical scheme contribution credit is available to taxpayers who belong to a medical scheme, set at a fixed amount per month for the taxpayer and first dependant, and two-thirds of this amount for additional dependants, adjusted annually for inflation. In 2011/12 amounts of R216 each a month for the taxpayer and first dependant, and R144 a month for each additional dependant, are proposed.
- A supplementary medical scheme contribution credit of R216 a month is proposed for members or dependants aged 65 and above, and members or dependants with a disability.

In addition, this document also seeks to explore the way forward on the tax treatment of out-of-pocket medical expenditures.

Collection and administration of contributions

Contributions to a National Health Fund may be collected by existing government institutions such as the South African Revenue Service. The Government Employees Medical Scheme (GEMS) is also viewed as a possible alternative vehicle for the collection of contributions.

The pooled National Health Fund will be administered through a single agency, possibly the South African Social Security Agency or GEMS, while administration and risk management costs will be set by Parliament.

The single-payer model is likely to result in significantly lower administrative, risk management and transaction costs which will in turn minimise non-healthcare costs.

Provision of healthcare services


Healthcare services will continue to be provided by both public and private healthcare service providers as is currently the case. All private medical practitioners will be contracted to the NHI but may continue to supplement their income by serving those who have top-up insurance.

General practitioners will play a key role in an NHI system and act as coordinators of care, ensuring appropriateness and cost-effectiveness of care.

The timing

Government's healthcare priorities from 2009 to 2014 are set out in the so-called "ten point plan for healthcare" which is set out below:

The Minister of Health is on record as having said that he will not implement the NHI on a public health sector which is not functioning or being managed properly. The first task of government in implementing an NHI system is therefore to overhaul the public health sector at all levels and to prioritise the quality improvement plan for public healthcare facilities.



The Minister of Health is on record as having said that he will not implement the NHI on a public health sector which is not functioning or being managed properly.

1			
Provision of strategic leadership and creation of a social compact for better health outcomes			
1.1	Adopt annual integrated plans to ensure unified action across the health sector in pursuit of goals	Draft Annual National Health Plan produced and presented to the National Health Council	Sep - 09
		Final Annual National Health Plan adopted by the National Health Council	Dec - 09
1.2	Development of a Social Compact for better health outcomes	National Consultative Health Forum conceptual framework adopted by the NHC	Oct - 09
		National Consultative Health Forum convened to define and adopt a social compact	Dec - 09
2			
Implementation of the National Health Insurance (NHI)			
2.1	Finalise policy proposal on the NHI	NHI policy document released for public comment	Nov - 09
		Revised NHI policy document incorporating public comments produced and presented to Cabinet	Apr - 10
2.2	Finalise draft of legislation to support the creation of the NHI	Draft NHI legislation presented to Cabinet	Jul - 10
2.3	Set up National Quality Management and Accreditation Body	National Quality Management and Accreditation Body set up and functional	Mar - 10
2.4	Perform an audit of Health ICT at all levels of the National Health System public sector only	Draft Health ICT Audit Report with recommendations produced and presented to the National Health Council	Oct - 09
		Final Health ICT Audit Report presented to and adopted by the NHC	Nov - 09
2.5	Draft the National ICT Strategy for Health	Draft National ICT Strategy for Health produced and presented to the National Health Council	Nov - 09
		Final National ICT Strategy for Health presented to and adopted by the NHC	Mar - 10
3			
Improving the quality of health services			
3.1	Implement quality improvement plans for the 18 identified health districts	A report on the improvement of services in the 18 identified health districts	Mar - 10
3.2	Refine and scale up a detailed plan on the improvement of quality of services and direct its immediate implementation	Adoption and implementation of quality improvement plans, covering infection prevention and control measures, waiting times and cleanliness	Sep - 09
	1 000 out of 3 818 public health facilities with Quality Improvement Plans (QIPs) covering safety, infection prevention and control measures, waiting times and cleanliness.		Mar - 10

4			
Overhauling the healthcare system and improve its management			
4.1	Draft proposals for legal reforms to unify the public health service	Draft proposals for legal reforms presented to the NHC	Nov - 09
		Final proposals for legal reforms adopted by the NHC, processed and tabled before Cabinet	Mar - 10
4.2	Develop a decentralised operational model including new governance arrangements	Proposal for a decentralised operational model approved by the NHC	Mar - 10
4.3	Finalise delegations for all managers at all levels of the public health system, with special attention on hospital managers or CEOs to ensure decentralisation of management	Delegations approved by the NHC	Dec - 09
		350 out of 400 Chief Executive Officers (CEOs) provided with written delegations	Dec - 09
4.4	Develop an accountability framework for the public and private sector	Draft accountability framework approved for the start of a wider consultative process	Mar - 10
4.5	Strengthen health-specific management capacity for programmes and facilities, especially hospitals	150 out of 400 CEOs enrolled on to the Hospital Management Training Programme	Mar - 10
4.6	Evaluate all CEOs of hospitals to ensure that they meet minimum requirements for effective management of the said facilities, and institute corrective measures where indicated, including retraining and/or redeployment	Submission to Cabinet of a report on qualifications, skills, competencies of CEOs and corrective measures taken or implemented	Mar - 10
4.7	Do a feasibility study for the establishment of a leadership academy for health managers	Feasibility study completed and presented to the NHC	Dec - 09
		Final report on feasibility study completed	Mar - 10
4.8	Evaluate and strengthen the District Health System and Primary Health care	A report on the evaluation and strengthening of the DHS and PHC submitted to Cabinet	Mar - 10
5			
Improved human resources planning, development and management			
5.1	Review and refinement of the Human Resources Plan for Health	A report on the review of the Human Resources Plan for Health submitted to the Minister	Oct - 09
		A revised Human Resources Plan for Health adopted by the NHC	Mar - 10
5.2	Review all policies, legislation, regulations and directives that led to the closure of nursing schools and colleges	A report on the review of policies, legislation and directives on the reopening and/or development of nursing schools and colleges submitted to the Minister	Oct - 09
5.3	Draft plans and allocate resources for the reopening of nursing schools and colleges in the 2010 academic year	Implementation plans and resources for the reopening of nursing schools and colleges approved	Dec - 09

5.4	Finalise plans for the creation of auxiliary personnel, including a framework for task shifting, for all categories of health professionals	Plans of new auxiliary personnel for all categories of health professionals approved	Mar - 10
5.5	Expand the scope and numbers of Community Health Workers	Plans and progress reports on the expansion of the scope and numbers of CHWs submitted to the Minister	Mar - 10
5.6	Develop norms and standards for Human Resources for all levels of the health system	Progress report on the development of HR norms and standards produced	Dec - 09
		Work plan for the development of HR norms and standards, including an outline of required resources produced	Aug - 09
		Draft HR norms and standards submitted to the Minister	Mar - 10
5.7	Increase access by and training output of targeted groups, namely Historically Disadvantaged Individuals (HDIs), women, persons with disabilities and youth from academic health complexes	A report on the baseline and plans to increase access and training output from 2010 submitted to the Minister	Dec - 09
5.8	Review the accessibility and training output of academic health complexes	Submit a report on the review of accessibility and training output of academic health complexes	Mar - 10
6			
Revitalisation of infrastructure			
6.1	Develop a National Health Infrastructure Plan that incorporates the use of PPPs and that is also based on the 2010 infrastructure delivery model	Draft National Health Infrastructure Plan incorporating the use of PPPs submitted to Cabinet for consideration	Dec - 09
6.2	Urgent implementation of refurbishment and preventative maintenance of all health facilities	Submit a report to NHC indicating that the refurbishment and preventative maintenance, based on the resolution that 3 to 5% of budgets be used for the purpose, is implemented in all health facilities	Mar - 10
6.3	Strengthen provincial departments of health capacity to deliver and maintain health infrastructure for primary and secondary health facilities	Report on the capacity and performance of provincial government in the delivery and maintenance of health infrastructure submitted to Cabinet	Mar - 10
6.4	Review the funding of the revitalisation programme and submit proposals to get participation of the private sector to speed up this programme	Funding of the Hospital Revitalisation programme reviewed and proposals on the participation of the private sector submitted to Cabinet for consideration	Dec - 09
6.5	Finalise the Health Technology Plan and Strategy	Draft Health Technology Plan and Strategy submitted to the NHC	Dec - 09
		Health Technology Plan and Strategy approved by the NHC	Jan - 10
		Health Technology Plan and Strategy incorporated into provincial Department of Health plans	Mar - 10
6.6	Finalise the Health Technology policy and regulations	Draft 1 of Health Technology policy and regulations submitted to NHC	Mar - 10

7
Accelerate implementation of the HIV and AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases

7.1	Implementation of the Prevention of Mother To Child Transmission (PMTCT) and Paediatrics Treatment and Adult Treatment guidelines	80% of eligible pregnant women initiated on ARV PMTCT dual therapy	Mar - 10
		80% of eligible HIV-exposed infants initiated on ARV Paediatric Treatment, viz. dual therapy	Mar - 10
		33 000 eligible new children patients initiated on Antiretroviral Treatment (ART)	Mar - 10
		30% of eligible pregnant HIV positive women initiated on Highly Active ART	Mar - 10
		215 000 eligible new adult patients initiated on ART	Mar - 10
		35% of eligible TB and HIV co-infected patients to started on ART	Mar - 10
7.2	Strengthen programmes against TB, MDR-TB and XDR-TB	80% of health facilities appropriately implementing TB guidelines	Mar - 10
		2 000 professionals trained in the management of TB, MDR-TB and XDR-TB	Mar - 10
		2 500 non-professionals (Community Health Workers) trained in the management of TB, MDR-TB and XDR-TB	Mar - 10
7.3	Collaborate with United Nations agencies and other multi-lateral bodies for technical support	Progress reports on collaborative efforts submitted to the NHC and SANAC	Mar - 10
7.4	Mobilise financial and other resources from the Global Fund and other major donors	A report on resource mobilisation submitted to the NHC and SANAC	Mar - 10
8 Mass mobilisation for better health for the population			
8.1	Intensify health promotion programmes	Health Promotion Strategy approved	Dec - 09
		Health Promotion Strategy incorporated into Provincial Health Promotion plans	Mar - 10
8.2	Intensify the implementation of programmes to attain the Millennium Development Goals (MDGs). Strengthen programmes focusing on Maternal, Child and Women's Health	The Perinatal Problem Identification Programme (PPIP) fully implemented in the 18 priority health districts	Mar - 10
		The Household and Community component of the Integrated Management of Childhood Illnesses (IMCI) fully implemented in the 18 priority health districts	Mar - 10
8.3	Focus on non-communicable diseases, injuries, patient rights and quality plus provide accountability	The diabetes declaration The strategy on unintentional injuries fully implemented by all 18 priority health districts	Mar - 10

8.4	Finalise and implement the Health Promotion Strategy targeting the Youth	Adoption and implementation of the Health Promotion Strategy targeting the Youth	Mar - 10
8.5	Strengthen community participation mechanisms, governance structures and consumer bodies to improve the health of the population	A report on the strengthening of community participation mechanism, governance structures and consumer bodies submitted to the NHC	Mar - 10
8.6	Strengthen health programmes focusing on disabled persons	National health cross-cutting programmes focusing on the disabled approved	Dec - 09
9			
Review of drug policy			
9.1	Develop a proposal and strategy for policy review	Approved proposal and strategy signed off by the Minister	Dec - 09
9.2	Review the Drug Policy	Final report on the reviewed Drug Policy approved	Mar - 10
9.3	Improve drug supply and management	Less than 3% stocks-out of total number of ARV (45) and TB (35) medicines on tender in nine provinces	Mar - 10
		90% availability of medicines in all facilities in nine provinces	Mar - 10
9.4	Draft plans for the establishment of a state-owned drug manufacturing entity	Approved proposal and strategy for the establishment of a state-owned drug manufacturing entity	Mar - 10
9.5	Strengthen all work and efforts to ensure affordability of drugs	A report on programmes to reduce the cost of drugs submitted to the NHC and Cabinet	Mar - 10
10			
Strengthen research and development			
10.1	Research to accurately quantify Infant Mortality Rate	The South African Demographic and Health Survey 2008 published	Mar - 10
10.2	Research into the impact of social determinants of health and nutrition	Research commissioned	Dec - 09
10.3	Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines	A report on the National Department of Health support for research studies on indigenous knowledge systems and the use of appropriate traditional medicines submitted to the NHC	Dec - 09
10.4	To support health research that promotes partnerships that protect health from climate change	A report on the National Department of Health support for research studies on health and the environment submitted to the NHC	Mar - 10
10.5	Improve the research output, especially from formerly disadvantaged health training institutions	A report on the baseline and plans to increase research output from 2010 submitted to the NHC.	Dec - 09
10.6	Review the research capacity of academic health complexes	A report on the review of research capacity of academic health complexes submitted to the NHC	Mar - 10

The status of progress and action plans against the timelines of the ten-point plan are not clear at this stage although during his speech on 31 May the Minister was very clear that the focus remains on re-engineering the public healthcare system which he described as "... unsustainable, ... extremely costly and ... hospicentric or curative in nature".

If the NHI is indeed the end point and the beginning is the revitalisation of infrastructure as outlined in the ten-point plan, the NHI would seem to be some way off.

More questions than answers

Although we have some indication of the future, the devil is in the detail and many fundamental questions remain unanswered:

1. What exactly is the definition of the basic level of NHI care which seems to be a contradiction in terms to the comprehensive benefit structure as envisaged by the NHI Task Team? How do these comprehensive benefits relate to the Prescribed Minimum Benefits (PMBs), both the Chronic Disease List (CDL) and the Diagnosis and Treatment Pairs (DTPs)?
2. In terms of affordability of the mandatory NHI for all South Africans, particularly because of the comprehensive benefit package it will offer, the following questions: How exactly will the tax structures be changed?
 - a. Will the tax structure relevant to employee benefits be fundamentally restructured?
 - b. Will the tax subsidy of medical scheme contributions be reformed to reduce the indirect



Will NHI create incentives for healthcare professionals to return from the private to the public sector?

synergies such as the sharing of resources to improve efficiencies in both sectors?

6. How long will it take and is there a political commitment to see through the massive upgrade the faltering South African public healthcare service delivery system that serves the majority of the population and which will be the backbone of service delivery for NHI?
7. Will the private and public sectors prioritise the development of funding and delivery of appropriate low-cost products (basic healthcare packages), which are to be purchased from both the public and private sectors at affordable rates? (These products are currently non-existent except for the low-cost Sapphire option of GEMS. In fact, the Parliamentary Portfolio Committee on Health indicated that government is considering opening the GEMS to everyone as a basis for the NHI.)

Hopefully many of these concerns will be laid to rest when the discussion paper is finally issued.

- c. funding of the private sector?
- c. Can the taxpayer afford the additional tax burden?
- d. With the constant spiral in the cost of healthcare, will government be forced to offer ongoing increasing subsidies for NHI, which could increase the tax burden on an ongoing basis, e.g. in the case of GEMS where government has been forced to offer subsidies of up to 75% to its employees to make mandatory membership to this medical scheme affordable?
3. Could the resultant restriction of the scope of the private healthcare funding industry (medical schemes, administrators, managed care organisations) be leading to its redundancy? Will there be opportunities for this industry within the NHI process?
4. Could the South African private healthcare service delivery that serves the minority of the population, but ranks in the top seven out of fifty comparable countries in terms of quality and cost, become negatively affected by NHI?
 - a. Will the NHI regulatory framework ensure fair and transparent fees for healthcare providers in order to prevent further emigration and attract back those who left the country to work in other countries?
 - b. Will NHI create incentives for healthcare professionals to return from the private to the public sector?
5. Will the public/private interface be improved so as to explore various

New trends in **HIV** management



Beulah has a background in journalism and marketing with a particular interest in language and communications. She began her career in the healthcare industry in 1993, working for Quality Health Services. After a six-year stint in the United Kingdom, where she honed her skills in journalism and marketing, she returned to South Africa and joined the Aid for AIDS team in 2009. A number of her articles dealing with HIV and related topics have been published in various newspapers.



Beulah Neelmeyer,
Senior Specialist: Marketing and
Communications, Aid for AIDS

HIV is now a preventable and relatively easily treatable chronic infection. Patients adhering to their treatment regime and receiving optimal care, can look forward to a near-normal lifespan and a fulfilling, productive life. In addition, current treatment options are far simpler, more effective and less toxic than ever before.

What are some of the contributing factors to the positive and significant progress that has been made in terms of managing HIV today?

Advances in prevention

Prevention methods today encompass more than simply abstinence or the use of condoms. Male circumcision is now believed to greatly reduce the chances of HIV transmission and is encouraged in adult males who were not circumcised at birth.

In addition, researchers have achieved an important scientific breakthrough in the fight against HIV with a vaginal gel that significantly reduces a woman's risk of being infected with the virus.

Aggressive prevention of mother-to-child HIV transmission has high impact results and is very cost-effective.

Studies have found that transmission of the virus from an HIV-positive person adhering to the appropriate antiretroviral therapy (ART), is greatly reduced (some studies indicate by as much as 92% less). This is because ART can lower the viral load in the blood and genital secretions to an undetectable level, thus making the individual much less likely to pass on the virus.

This is referred to as "treatment as prevention" and highlights the need for people living with HIV to seek out appropriate care and adhere to their treatment regime.

Testing of couples is now widely encouraged where appropriate.

Advances in HIV testing

Funders, including government, medical schemes and corporations, have seen the value of including HIV testing within "wellness" assessments to improve uptake.

Testing of couples is now widely encouraged where appropriate. This "couples" approach is believed to make a big difference in terms of encouraging the need to know one's HIV status and inviting responsible and open communication between couples regarding their sexual behaviour.

The simplicity and accuracy of the tests available today also contribute greatly to the success of mobilising people to get tested.

Aid for AIDS has introduced a powerful tool into their HIV Counselling and Testing (HCT) campaigns to ensure that individuals who test positive are immediately enrolled on the Disease





Management Programme. This is done by means of a pre-registration process at the point of diagnosis and gives the individual an opportunity to access care and support, and when appropriate, treatment for their condition.

Advances in therapy

Treatment of HIV today is simpler, better and faster. This is made possible by new formulations (e.g. a 3-in-1 daily tablet, Atripla®), the availability of many low-cost generics and a host of refinements to existing drugs and clinical profiles, based on substantial advancements in understanding how to manage the virus.

The benefits of starting ART earlier are now clearly established and the use of ART in pregnancy, children, adolescents and the elderly is now also better understood.

Better understanding of disease progression and impact of ART

Thanks to research and experience, a number of issues in this regard are better understood. For example, untreated HIV is associated with an increased risk of non-HIV (especially cardiovascular) disease and premature ageing.

The benefits of starting ART earlier are now clearly established and the

use of ART in pregnancy, children, adolescents and the elderly is now also better understood.

Conclusion

The positive statement at the beginning of this article that HIV is now a preventable and relatively easily treatable chronic infection is made possible by the latest developments.

However, many challenges still remain:

- Many people still do not know their HIV status.
- Stigma and denial persist (although progress has been made).
- Behavioural change (reduction in number of sexual partners, delaying the sexual debut, encouraging safer sex, etc) – is an uphill battle.
- Encouraging patients to stay adherent to their treatment.
- Tuberculosis and Hepatitis B virus co-infection with HIV.

Nonetheless, a retrospective look at the incredible progress that's been made with regard to managing HIV during the last 12 years is certainly enough to justify a positive outlook on the prospects of future progress.

The role of Aid for AIDS as a disease manager over that period of time has positively impacted directly on the lives of more than 165 000 HIV positive patients. The value of the benefits derived from well-managed patients on the programme extend to their families and ultimately their communities as well.

AfA looks to the future and is committed to continue to pay the leading role in the response to HIV in the private sector in South Africa.

Editorial committee



Charles Ranger
BCom - MBA
General Manager: Medscheme Health

After receiving his BCom, Charles began his career as an assistant accountant in the agricultural sector before moving into financial services. Having completed his MBA, he took up a career in the healthcare industry before accepting a position at Medscheme. He was appointed General Manager, Fedhealth in 2006 and currently looks after Fund Management, Sales and Marketing as well as Operations for the medical scheme.



Mike Duly
CFP
Senior Manager: Branding and Communications

Mike obtained a dual Fellowship in Healthcare and Employee Benefits from the Financial Planning Institute (FPI) before studying strategic marketing and communications at Wits Business School. He has extensive marketing and communication experience in the healthcare and financial services industries and has been instrumental in implementing Medscheme's communication and branding strategies.



A Member of AfroCentric Group



Disclaimer

Medscheme Holdings (Pty) Limited does not assume and hereby disclaims any and all liability to any entity for any claims, damages (direct, indirect, consequential or otherwise) or other loss including, without limitation, any liability for injury or other damages resulting from any use of or reliance on the information contained in this publication.