DECEMBER 2021

# BHF360°

*into healthcare*

## THE GREAT RESET

## Leveraging the power of cohesion

*A unified sector will better meet the needs of the health citizen*

**COVER: In conversation with Barloworld Medical Scheme's Pontsho Mokoena p. 16**

SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

# THE BEGINNING OF A REVOLUTION IS HERE

The Council for Medical Schemes gave its stamp of approval to the merger of Hosmed Medical Scheme and Sizwe Medical Fund, creating South Africa's eighth-largest open medical scheme, marking the beginning of a revolution in South Africa's medical scheme industry. The merger brings together Sizwe's 46 900 membership with Hosmed's 21 000, according to these membership numbers, the merged entity becomes the 8th largest medical scheme in the country with the fourth-highest solvency ratio of the top ten largest medical schemes

"There are no words to describe the significance of the series of events and business decisions that have been crowned by the birth of the entity that is Sizwe Hosmed Medical Scheme," says Dr Simon Mangcwatywa, Sizwe Hosmed's Principal Executive Officer.

"We can all be proud to bear witness to the birth of Sizwe Hosmed, as it represents the collective (proverbial) blood, sweat and tears of a group of individuals with the tenacity to see through a shared vision to its fruition," he added.

A few developments in recent years have placed pressure on smaller medical funds, creating increasing pressure for consolidations; these include a review of the Prescribed Minimum Benefits package, the drive towards implementing a National Health Insurance, and an expected increase in claims in the wake of the COVID-19 pandemic.

"This merger is mutually beneficial to both schemes, where the combined balance sheet and increased membership size can unlock efficiencies and economies of scale to the benefit of all members," said Dr Simon Mangcwatywa "Sizwe Hosmed members will benefit through a reduction in non-healthcare expenses attributed to reduced operational scheme expenses"

Sizwe Hosmed Medical Scheme's work force will continue to provide the excellent level of service and support that our members have come to expect

The history behind both brands allows for the engineering of a legacy in health insurance that the new entity, Sizwe Hosmed is braced to build, representing a collective 80 years - covering the South African public with a blanket of medical insurance products "The creation of a legacy itself is akin to planting a tree- the shade of which we will all live to enjoy. This institution has the bones and structure to outlive the youngest of us and benefit the health and well-being of generations to come"

The members of the new scheme are critical to the success of Sizwe Hosmed: "We must also acknowledge the role of every member of the respective schemes, who have entrusted us with their health, and that of their families and loved ones for decades. These members are relying on our collective ability to steer them through this transition, and it is our duty to ensure that we protect each one of them to ensure no member is left on the sidelines of this merger."

Looking ahead to the future defined by the success of Sizwe Hosmed Medical Scheme, Dr Mangcwatywa said," As we step into the new journey of this medical scheme, we must remember what lies at the base of our operations. We are working not for ourselves and our own benefit- but for the generations ahead of us, to ensure that this legacy tree will stand firmly rooted, offering safety and protection under the comfort of its shade."

# BHF360°
*into healthcare*

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# From the EDITOR'S DESK

Welcome to the 2021 edition of BHF360°. Two years later the COVID-19 pandemic has severely impacted various health systems, deepened the challenges and widened the socioeconomic-related health inequality in the region. But the crisis has also presented us with the opportunity to reset, as we open our minds to the possibility of a world that looks different from our current reality. The time has come for the healthcare industry to leverage the power of cohesion and collaboration to create innovative solutions that will transform and accelerate change.

For the second year in a row, COVID-19 forced us to cancel our annual conference, but we are looking forward to welcoming you back in 2022. In the meantime, we hope as usual that you find the magazine informative and entertaining.

According to the WHO, 70% of the global workforce are women; yet somehow, gender equality in healthcare remains a figment of our imagination. An in-depth feature offers suggestions on how to accelerate it and emphasises the need for measurable instruments to ensure this. A more personal perspective on the issue is offered by our cover personality, Pontsho Mokoena, CEO of Barloworld Medical Scheme, as she looks back on her career and her experience as a woman in the healthcare industry.

A thoughtful opinion piece by Dr Guni Goolab spotlights the lessons learned from the COVID-19 vaccine rollout collaboration by the industry. As usual, our other SADC member countries provide annual updates. As was to be expected, the response to COVID-19 is the dominant theme of these reports.

The above are just a few examples of what you can expect to find in these pages. I would like to wish you all a safe and happy holiday season. See you in 2022.

**Zola Mtshiya**
*Head of Stakeholder Relations and Business Development, BHF*

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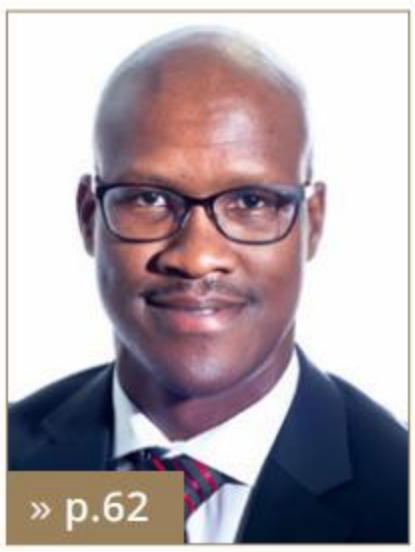
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# A beacon of hope in a sea of distress

## *The call of duty with the vaccine rollout*

By Dr. Guni Goolab

Non - Executive Director, Lenmed

Since 1994, South Africa has achieved many important successes. We have a stable democracy, free press and an independent judiciary. There have been many socio-economic gains, such as the school feeding scheme for nine million children, pension, disability and child support grants, with the combined social grants exceeding eighteen million recipients. There has been good progress in access to housing, electricity, water and sanitation.

Despite these areas of important progress, we have faced significant self-inflicted hurdles over the past decade, under the Zuma-led administration, with growing unemployment, poverty and rising inequality, as a result of rampant corruption, wholesale state capture and low economic growth.

In the area of healthcare, the major area of success has been the successful ARV rollout for HIV/AIDS, across both the public and private sectors, adding almost 10 years to life expectancy over the past decade.


*COVID-19 has accelerated and deepened all the challenges South Africa has been facing. It can no longer be business as usual. Universal Health Coverage through the introduction of an appropriate and phased NHI, built on the preceding changes, has to be part of the way forward.*

The publication of the National Health Insurance (NHI) White Paper and the Health Market Inquiry (HMI) Report represents key milestones on the road to transforming the healthcare sector in South Africa. The essence of these documents highlights the need for transformation of both the public and private sectors: the public sector needs to deliver more access and capacity in terms of people, systems and infrastructure, while the private sector requires improved affordability and productivity as well as less wastage. Both systems need better governance and must focus on access, affordability, quality and outcomes. There is certainly a need for greater coordination, collaboration, synergy and integration in the service of the health citizen.

Adding to the list of challenges in South Africa's healthcare sector, as well as the rest of the world, is the COVID-19 pandemic. There can be no doubt that the world and South Africa are in the midst of a massive crisis. COVID-19 has accelerated and deepened all the challenges South Africa has been facing, such as inequality, poverty and unemployment. Over the last 20 months, unemployment has reached the highest levels ever recorded, with approximately two million jobs lost, mainly among low-income black women, particularly in the domestic worker and farm worker occupations.

We have had massive disruption in schooling, with loss of learning for especially rural and township school children who have limited access to data and the internet; this has been exacerbated by the interruption of the school feeding programme, which has left many children experiencing increasing levels of hunger.

Finally, we have seen even greater levels of inequality, which is distressing, given that we are already the most unequal society in the world with a deep racial undertone – with the rich mainly white and the poor mainly black. This inequality reached a tipping point when scenes of looting and violence erupted across the country in July 2021, aggravated by the discontinuation of the R350 COVID-19 grant.

The healthcare system needs change:

- The public health sector has challenges of limited access due to shortages of healthcare workers, infrastructure and medicines as documented in the NHI paper.
- The private health sector has challenges in respect of affordability and sustainability as articulated in the HMI report.

# AT A GLANCE

## National Vaccination Programme rollout

The key elements of the National Vaccination Programme rollout, with the overall governance and accountability, are as follows:

**Product/service:** Pfizer and J&J vaccines

**Kick-off/launch:** 17 May 2021

**Overall accountability:** National Department of Health (NDoH)

**Importation of vaccines:** NDoH

**Distribution:** DSV and Biovac

### FUNDING OF VACCINES:

National Treasury and the Council for Medical Schemes (CMS) list COVID-19 as a prescribed minimum benefit, including vaccines and vaccination. ***These are delivered free at the point of service to all citizens, by both public and private providers.***

### ACCREDITATION OF VACCINATION SITES:

The Pharmacy Council and NDoH, using an online platform for site registration on Master Facility List and Electronic Vaccination Data System (EVDS) and Section 22A licence.

### TRAINING OF VACCINATORS:

NDoH using an online platform, Knowledge Hub.

### REGISTRATION OF CITIZENS:

Essential basic information to register, schedule and record vaccinations, along with the vaccination certificate (basic form of health record) on EVDS developed by NDoH.

### SERVICE DELIVERY:

Public sector – academic and provincial hospitals and community health clinics, including mobile/outreach services.
Private sector – pharmacies, hospitals, medical aid administrators, GPs, occupational health providers through companies in the mining, motor and manufacturing industries, and the informal and NGO sectors, e.g. the taxi Industry, religious and community sites and mass vaccination sites – Moses Mabida Stadium and Cape Town ICC.

It cannot be business as usual. Universal Health Coverage through the introduction of an appropriate and phased NHI, built on the preceding changes, has to be part of the way forward.

Over the past nine months, a number of volunteers have contributed to the Phase 2 rollout of the national vaccination programme that commenced on 17 May 2021, either as pro bono individuals or seconded from organisations including Insight Actuaries & Consultants, Afrocentric, Universal, the BHF, Aspen Pharmacare and Discovery Health.

The national vaccination rollout is an excellent intervention that makes one hopeful about what might be possible to achieve through NHI, when the best of both the public and private health sectors are brought together in the pursuit of a single national public health priority.

The programme has demonstrated elements of pooling, purchasing, accreditation, contracting and health records – all key elements of a NHI. However, more importantly, it has demonstrated the incredible level of collaboration, partnerships and innovation between business and government, between the public and private health sectors, between parts of government – Treasury, national and provincial government structures, between business, labour and civil society/NGOs, and between medical

## WHAT HAS BEEN ACHIEVED TO DATE?

1. Over 20 million vaccinations administered.
2. An average of one million vaccinations per week or 200 000 per day.
3. Currently about 50% of all vaccinations are being administered in the private sector.
4. Both uninsured and insured citizens have been directed to or voluntarily selected either public or private sites, receiving the same vaccine and vaccination service free at the site of delivery, irrespective of age, disease, demographic and ability to pay.

*Dr. Guni Goolab, Non - Executive Director, Lenmed*

aid administrators, hospitals, pharmacists, GPs and occupational health providers.

There have been some truly unique, inspirational and innovative collaborations during this period.

The rollout to healthcare workers was done as a large open label trial under the Sisonke programme with the Medical Research Council, J&J and NDoH reaching almost 500 000 healthcare workers with a unique data set. The registration and enrolment was undertaken using the tool, Vaccines for Healthcare Workers, developed by GPs linked to the Independent Practitioner Association Foundation – a true South African first!

The participation of the private business constituency through B4SA must be commended, as must the similar commitment from the NDoH. The delivery of vaccinations at places of work, including mining, motor, manufacturing and taxi sites was uniquely South African, and required an incredible level of public/private collaboration. So too did the delivery of vaccination services to pensioners at South African Social Security Agency (SASSA) and other pension pay-points at month end by Right to Care.

The rapid teacher vaccination roll-

> I believe that the healthcare sector has the ingredients to be a key pillar of our economic recovery, ensuring long-term sustainability and inclusive employment-driven economic growth comparable to the impact of the much-vaunted motor industry.

out by the NDoH in conjunction with the provinces, followed by the rollout to the police service and finally higher education institutions, entailed unprecedented collaboration between medical aid administrators Medscheme, Discovery Health and Momentum, backed by the analytical capabilities of Insight Actuaries & Consultants, the switching capabilities of Medikredit and the contracting services of Webber Wentzel and Bowmans' legal firms.

The EVDS capabilities of the NDoH and the resources provided by the Minerals Council from the mining sector also supported the workplace-based vaccination programme. The collaboration at the B4SA funding workstream across both the BHF and HFA, led by Discovery, delivered the funding mechanism for public and private patients receiving their vaccine at private healthcare facilities. Also, input was made into the vaccine acquisition price and the vaccine administration fee.

As I reflect on this period of extraordinary collaboration between the public and private sectors, I believe that in the future this can form the basis for a more long-term collaboration on the following national health priorities:

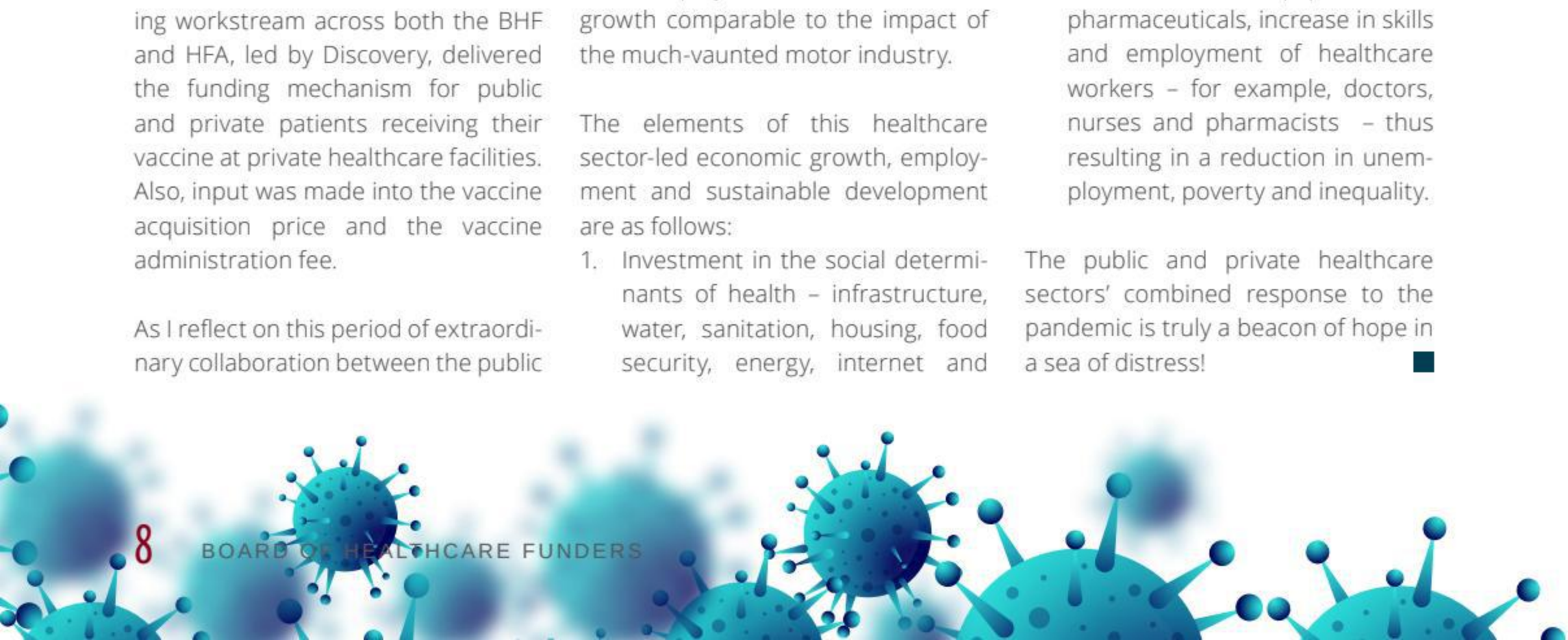
1. Rollout of all appropriate vaccines to the general population
2. Management of all HIV and AIDS patients
3. Management of all diabetics and the provision of dialysis
4. Reducing the backlogs in cataract, knee and hip surgery in the public sector.

Finally, I believe that the healthcare sector has the ingredients to be a key pillar of our economic recovery, ensuring long-term sustainability and inclusive employment-driven economic growth comparable to the impact of the much-vaunted motor industry.

The elements of this healthcare sector-led economic growth, employment and sustainable development are as follows:

1. Investment in the social determinants of health – infrastructure, water, sanitation, housing, food security, energy, internet and data access, resulting in increased investment in the economy, gross fixed capital formation, GDP growth and reduction in unemployment, poverty and inequality.
2. Employment and skills development – increased need and capacity for doctors, nurses, pharmacists, allied health and community health workers, resulting in increased investment in education and skills and hence subsequent reduction in unemployment, poverty and inequality.
3. Investment in enterprise development – small businesses, personal protective equipment localisation and medical equipment suppliers, diagnostics, vaccines and pharmaceuticals, thereby resulting in a reduction in unemployment, poverty and inequality.
4. A strategic development plan for the health sector as a whole with investment in scientists through clinical trial programmes by multinational pharmaceutical companies, genomics and mapping of variants, increase in manufacturing capacity for vaccines, diagnostics, medical equipment and pharmaceuticals, increase in skills and employment of healthcare workers – for example, doctors, nurses and pharmacists – thus resulting in a reduction in unemployment, poverty and inequality.

The public and private healthcare sectors' combined response to the pandemic is truly a beacon of hope in a sea of distress! ■



# THE NATIONAL HEALTH INSURANCE BILL

## What will work, what needs to change

SELAELO MAMETJA
*MBBCh, MMED Public Health (FCPHM(SA), Chief Research Officer, GEMS*

Various arguments have been made pro- and anti-NHI as a financing mechanism for the country. Among many arguments is that South Africa already has existing Universal Health Coverage (UHC) through the tax-financed public sector- and medical scheme-funded private sector. Despite what many may define as UHC, both medical scheme beneficiaries and patients accessing state healthcare find that on the ground, both systems leave them vulnerable to lack of access (especially in resource-constrained public sector facilities), exorbitant premiums and out-of-pocket expenditures. The inequitable distribution of healthcare resources (e.g. hospitals, human resources) further exacerbates geographical and income disparities.

The introduction of NHI to advance equitable access to healthcare for all South Africans is both a moral imperative and a tool to advance our constitutional right to quality healthcare irrespective of our socio-economic means. Pooling of financing mechanisms and having a mandatory prepaid NHI will provide South Africans with equal opportunity to participate meaningfully in their healthcare financing, irrespective of their socio-economic means. The bill also outlines mechanisms to improve efficiencies, such as using general practitioners (GPs) as gatekeepers, referral pathways and formularies. A Government Employees Medical Scheme (GEMS) study has shown that this mechanism can improve efficiency and reduce costs by 16-20%.

*Section 27 of the South African Constitution guarantees everyone the right to healthcare and places upon the state a duty to take reasonable measures within its available resources to achieve the progressive realisation of this right. Therefore implementation of National Health Insurance (NHI) using various legislative frameworks is pro-South African Constitution.*
*The purpose of this article is to highlight what will work.*

NHI as a means to achieve equity is in line with international debates and policies. In countries where NHI exists, debates have shifted to reducing gaps in healthcare and ensuring equality. Among many determinants of health in South Africa, healthcare financing remains a key determinant of inequity. Equality has been on the South African agenda since 1994.

## RISK-POOLING

Risk-pooling is perhaps one of the things that can easily be achieved once the bill is approved. In creating a unitary fund, it is important to consider the uniqueness of South Africa. As part of health policy to expand access to healthcare, the state gazetted the Medical Schemes Act that allowed the existence of a high number of medical schemes.

The introduction of demarcation regulations under Section 70(2b) of the Short-term Insurance Act means that demarcation products continue to create fragmented risk pools. While the Medical Schemes Act is not pro-equity it did create some entitlements in the form of prescribed minimum benefits (PMBs). When consolidating medical schemes and other sources of financing, it is therefore imperative to ensure that no South African is left worse off than they were before, as the state is required by the Constitution to be progressive and not regressive in the realisations of healthcare.

### FOOD FOR THOUGHT

- Inclusion of a basic benefit package will create some form of assurance as well as a mechanism for accountability.
- A clinically sensitive and independent mechanism needs to be introduced as part of the governance structure within NHI.
- The bill must introduce a definition of quality healthcare and the requirements for the independent assessment thereof.

## ACCOUNTABILITY

The inclusion in the NHI legislation of something similar to the PMBs in the form of a basic benefit package will create some form of assurance as well as a mechanism for accountability. Such a basic benefits package needs to be both pragmatic and practical, and the public sector has introduced a similar mechanism in the form of the Essential Medicine List. The WHO recommends the commitment to a basic benefits package and refers to this as essential healthcare.

> “Implementation needs to be pragmatic and barriers to equitable and quality healthcare, such as fraud, waste, abuse and corruption, must be addressed.”

As a single purchaser, the government may lack the capacity to effectively negotiate fair prices. The private sector can collude and push prices up, or the government can negotiate poor quality at low prices. In the South African health market, a monopsonous purchaser will further entrench the imperfect and ineffective conditions, drive out small players and stifle productivity.

## DECENTRALISATION AND GOVERNANCE

South Africa has been considering the delivery of healthcare at district level. Although this has been advancing slowly, it is not clear how a single purchaser is going to advance decentralised healthcare. Furthermore, the governance structure gives the Minister all the powers. The NHI Bill tries to advance the contracting units for primary healthcare as devolved structures. However, their decision-making powers are not well defined.

The United Kingdom National Health Service has made a remarkable journey in the evolution of healthcare and balancing of powers. In 2012 it devolved to Primary Care Trust (PCT). By 2015, as part of the government's stated desire to create a clinically driven commissioning system that was more sensitive to the needs of patients, clinical commissioning groups led by GPs were established.

It is therefore imperative that South Africa similarly ensure that the single purchaser's desire for low prices does not compromise the population's

*Selaelo Mametja,*
*Chief Research Officer, GEMS*

healthcare needs and that we remain patient-centric.

A clinically sensitive and independent mechanism needs to be introduced as part of the governance structure within NHI. The NHI Bill refers to a Benefits Advisory Committee, which will also be appointed by the Minister and thus have no independence at all. In addition, it is necessary to have an independent body (i.e. independent of the fund and Minister of Health) to assess the quality of healthcare provided.

Accreditation of health facilities is a prerequisite, but it only addresses one of the three pillars of quality of healthcare: the structure, but not the processes and outcomes. Since quality and equity are the inseparable twins of healthcare, it is necessary that the bill introduce a definition of quality healthcare and the requirements for the independent assessment thereof.

## FIGHTING FRAUD AND CORRUPTION

A big uncertainty is whether the NHI fund can effectively pool resources and distribute them efficiently and equitably in the face of three big threats: fraud, corruption and the existing massive inequalities in social determinants of health.

According to Transparency International, South Africa ranked number 66/180 in terms of corruption; 65% of people thought that corruption increased between 2019 and 2020, and 18% of people have paid a bribe to a public sector official. Despite these statistics, COVID-19 has revealed that a lot of corruption took place. Like equity, corruption and fraud need to be recognised as key determinants of health and require the necessary redress.

> "Power tends to corrupt, and absolute power corrupts absolutely."
>
> *Lord Acton*

A robust and effective legal system is both a deterrent and tool to prosecute corruption. It is therefore important that the NHI Bill seeks to prevent corruption by ensuring that no individual has absolute power and by establishing a corruption-proof governance structure. The current governance structure has been criticised for giving the Minister of Health excessive powers and weaknesses in accountability. It is imperative to address the social determinants of health by ensuring that all policies address unemployment. This will be critical to the success of NHI.

In closing, South Africa needs to provide universal coverage through an equitable financing mechanism, and the NHI Bill provides for such a structure. However, the implementation needs to be pragmatic and barriers to equitable and quality healthcare, such as fraud, waste, abuse and corruption, must be addressed.

*Based on the inputs and presentations made to the Portfolio Committee on Health, it can be inferred that people are unsure if the Bill in its current form will achieve the objectives of universal health coverage.*

# What do people support, what are they concerned about?

VISHAL BRIJLAL
*Senior Director; Clinton Health Access Initiative*

Health forms an integral part of any country's development plan. South Africa is committed to providing universal health coverage (UHC) for all South Africans, enabling them to build good, healthy lives for themselves, and empowering vulnerable populations.

Section 44(1) of the Constitution establishes Parliament as the national legislative body; as such, Parliament has a crucial role to play in upholding the Constitution. Dr Frene Ginwala, former speaker of the National Assembly, said, "Parliament is the custodian of democratic values and the legitimacy of Parliament is based on the will of the people."

Since the National Health Insurance Bill was introduced to Parliament in August 2019, the Portfolio Committee on Health (PCH) has embarked on a process of obtaining public comment and inputs on the bill and has received in excess of 100 000 written submissions.

The Bill seeks to fulfil South Africa's commitment to the right to access affordable health services through the creation of the NHI fund (and associ-

ated structures), which will purchase quality health care services on behalf of all South Africans. This must be done in a way that ensures that access is equitable and without prejudice.

In May 2021, the PCH invited various individuals and/or organisations to make oral inputs in substantiation of their written inputs.

The inputs made to date highlight several concerns with regard to the Bill. When asked by the committee if they support NHI, virtually all those who gave input emphasised strong support for the principle of achieving UHC.

While this might seem one and the same, the difference is quite important. NHI has always been articulated by government as the vehicle for achieving UHC.

Based on the inputs and presentations made to the PCH, it can be inferred that people are unsure if the Bill in its current form will achieve the objectives of UHC.

So what do people support and what are they concerned about?

Based on the comments made, the PCH has much to deliberate over.

a) Areas of general support include: the establishment of a NHI fund, the need for a strong and independent board, the establishment of an appeals committee and process for complaints. There is support for a process that defines benefits and access to services.
b) Even though there is general support on these issues, there are concerns relating to the processes for achieving some of this, even though these do not reflect opposition to the principles.
c) There are a number of areas where inputs reflect limited support, due mainly to confusion and lack of clarity.
d) There are questions relating to the constitutionality, legality and feasibility of certain provisions. These include the role of medical schemes, primary healthcare contracting units (or CUPs), governance and issues of benefit design and pricing.

The PCH will need to ensure that the Bill makes provision for the establishment of a NHI fund in a transparent and accountable manner, coupled with greater clarity on the role and function of benefit design, pricing and accreditation. There will need to be changes to the transitional arrangements and the time it will take to achieve some of the objectives in the Bill before full implementation will occur.

The NHI requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds. More specifically, a robust risk management framework for NHI with all the necessary analytics and tools will be key to continually managing and mitigating risk. Preventative strategies for fraud, waste and abuse will also have to be deployed and there will need to be severe penalties for abuse.

**KEY REQUIREMENTS**

- NHI requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds.
- A robust risk management framework with all the necessary analytics and tools is required to continually manage and mitigate risk.
- Preventative strategies for fraud, waste and abuse will have to be deployed and there will need to be severe penalties for abuse.
- Provision must be made for the establishment of an NHI fund in a transparent and accountable manner,

Ultimately, if designed appropriately, NHI will ensure a more responsive and accountable health system that will likely improve user satisfaction, lead to better quality of life for citizens and improved health outcomes across all socioeconomic groups. It will also contribute towards improved human capital, labour productivity, economic growth, social stability and social cohesion.

# GEMS workplace immunisation increases COVID-19 vaccine coverage

## Background

At the beginning of the COVID-19 vaccine roll-out, South Africans competed for a space to get vaccinated. As part of the Government Vaccination Strategy, the government aims to immunise 67% of the population by the end of 2021. The strategy prioritised 1.25 million healthcare workers, of which 400 000 were vaccinated through the Sisonke Trial. The Government Vaccine Strategy took a three-phased approach prioritising the most vulnerable groups. Phase 1 focused on healthcare workers, who had to be vaccinated as part of the Randomised Control Trial phase 3b, named the Sisonke Trial. This followed a phased-in approach of age categories starting with those over 50 years. Teachers were included as part of essential workers during the third peak pandemic wave. At the time of writing, 11.6 million South Africans have received at least one dose of available Covid-19 vaccines, and 7.9 million have been fully vaccinated.

The World Health Organization (WHO) defines vaccine hesitancy as a "delay in acceptance or refusal of vaccines despite availability of vaccination services". It is important to make the distinction between the terms "antivax" and "hesitant". "Antivax" refers to people who are generally sceptical about vaccination, whereas "hesitant" refers to people who delay the process of vaccination due to a variety of concerns.

## GEMS workplace programme

GEMS collaborated with the National Department of Health (NDoH) and the Department of Public Service and Administration (DPSA) and embarked on a workplace vaccination programme, from the commencement of Phase 2 of the National Vaccine Rollout Programme. To date, more than 67% of our principal members have received at least one vaccine, with the basic education and health and social development employment sectors reporting relatively higher vaccination rates.

## GEMS Hesitancy Review

### Factors contributing to lower uptake of vaccines

Vaccine hesitancy is not a new phenomenon. Prior to the COVID-19 pandemic, South Africa had already reported levels of vaccine hesitancy towards vaccination programmes, identifying vaccine hesitancy as one of the main barriers towards optimal childhood vaccination.Vaccine hesitancy can usually be attributed to three factors: (1) what people think and feel (information, trust and efficacy); (2) social processes (lack of a strong social norm); and (3) practical issues (barriers to access).

Global mapping across 149 countries between 2015 and 2019 found that vaccine hesitancy is unpredictable over time and influenced by factors such as convenience, complacency, and confidence. A systematic review of vaccine hesitancy research related to COVID-19 conducted in 2020 found a vaccine acceptance rate of 77.6% among the general population compared to influenza vaccine hesitancy (69%). Vaccine hesitancy was declared one of the top ten threats to global health by the WHO in 2019.

Evidence suggests that improvement in overall policies can be used to identify and address gaps in adult immunisation coverage rates. Interventions include: (1) enhancing patient access to vaccination; (2) improving community and patient demand; and (3) provider- and healthcare system-directed interventions. Figure 1 below shows the Turner et al. 5C model of factors influencing vaccine hesitancy.

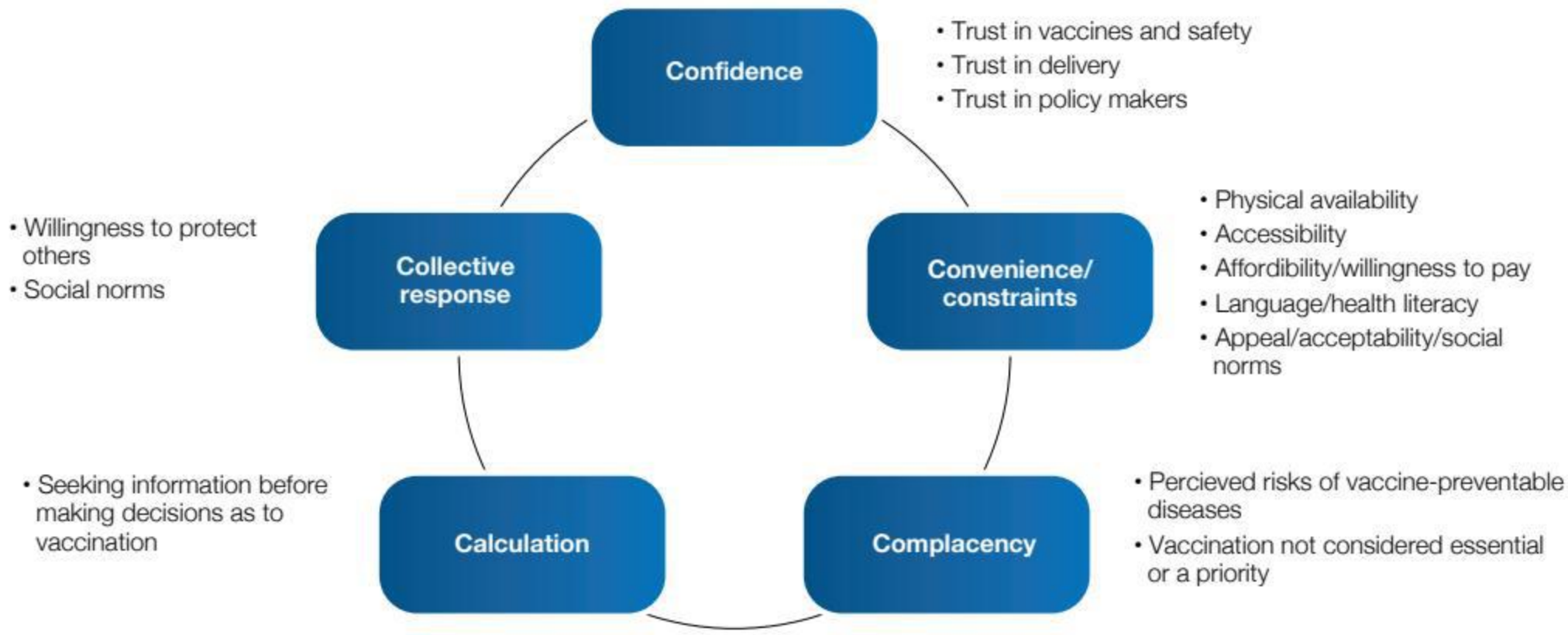



Figure 1: 5C model of factors influencing vaccine hesitancy and acceptance (Turner et al., 2021)

As part of a monthly satisfaction survey, GEMS has routine access to vaccine hesitancy rates. At the beginning of the survey, many members were hesitant (34%, January 2021) to receive a vaccine. Vaccine hesitancy among GEMS members has since dropped significantly (5%, August 2021) due to member education. Reported vaccine hesitancy was higher among the younger and senior age groups: 18-24 years, followed by 65 years and older (Figure 2). Among those with vaccine hesitance, the reasons cited include safety and effectiveness.

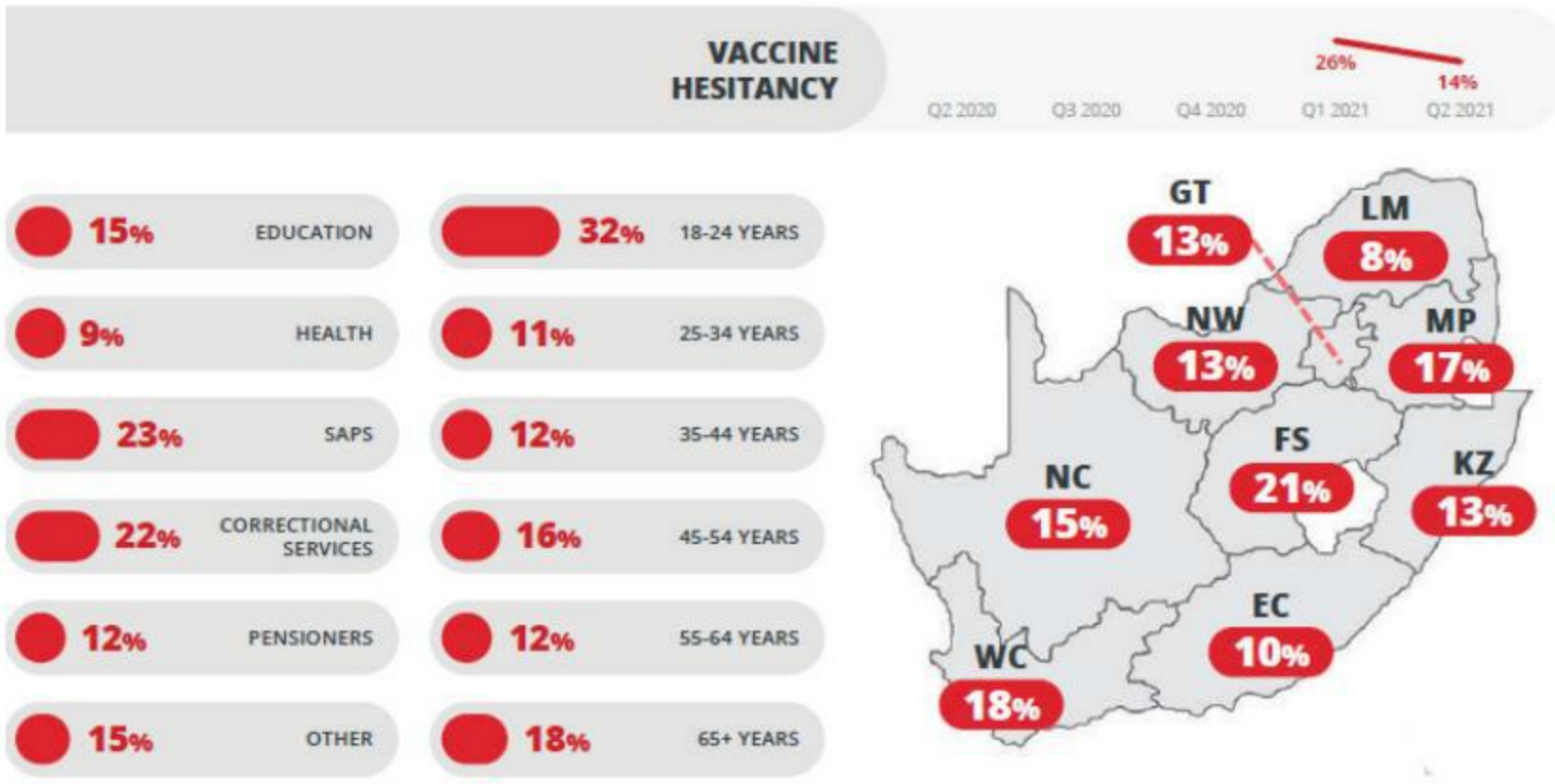



Figure 2: GEMS Q2 Member Vaccine Hesitancy (GEMS Citizen Survey Q2 Report)

Furthermore, the 2020 COVID-SCORE survey conducted in 19 countries, including South Africa, found that 82% of South Africans felt that COVID-19 vaccines are proven both safe and effective compared to the global average of 72%. However, only 46% felt comfortable allowing their employers to mandate vaccination compared to the global average of 48%

## Interventions to increase vaccine uptake

Member education in addressing the safety and efficacy of vaccines remains a crucial objective for GEMS. This strategy has clearly proven to be effective, as seen in the drop in reported vaccine hesitancy among GEMS members between January (34%) and August 2021 (5%).

**Examples of evidence-based interventions to increase vaccine confidence and uptake are:**

i. Educational campaigns, which include informational posters, educational materials, media awareness, health risk appraisal, and educational employee group sessions;

ii. Institutional recommendations where employers encourage vaccination and provide vaccination stickers;

iii. Vaccine champions who can be influential figures and promote vaccination;

iv. Reminders and recall in the form of letters, emails and telephone calls, which are suitable at walk-in-clinics for patient outreach and follow-up appointments;

v. Incentives for getting vaccinated, such as monetary incentives, raffles, lunches, and/or cash prizes;

vi. On-site vaccination to increase convenience and affordability for employees; and

vii. Workplace and school vaccination policies in which vaccination is required to attend a place of work or school, or a mandatory declination policy where employees sign a form stating that they understand the risks for themselves as well as for others while declining vaccination.

## Conclusion

Interventions that increase vaccination rates are those that directly impact behaviour, public health processes, and policy. These strategies cover interventional and educational campaigns targeted at populations prone to vaccine hesitancy. Research in low- and middle-income countries remains limited. However, studies in high-income countries show that the leading cause of COVID-19 vaccine hesitancy is the rapid pace at which the vaccines are being developed. Member education in addressing the safety and efficacy of vaccines remains a crucial objective for GEMS. This strategy was shown to be clearly effective, as seen in the decrease in reported vaccine hesitancy among GEMS members between January (34%) and August 2021 (5%) and the relatively high rate of vaccination (67%) among principal members.



ON THE COVER Q & A

# In Conversation With Pontsho Mokoena

## Principal Officer, Barloworld Medical Scheme

***We spent time with Ms Pontsho Mokoena to talk about her personal journey and role as principal officer, challenges and opportunities to improve access to health services***

### Tell us a bit about yourself.

I was born and bred in Tembisa in a home structured in discipline with a strong emphasis placed on academics. Our home was presided by both parents, who were entrenched in our home, schooling and social lives daily. The love and certainty received from my parents was more important that any financial lack we had and for me challenges the notion of humble beginnings as it defines the memory of my upbringing being one recalled for the strong sense of self and belonging as opposed to what we lacked financially. I was also fortunate that I could name my parents as my role models growing up and have witnessed the role of my mother morphing into her being my mentor in my adult life. Growing up, I was in awe of how my parents, who themselves didn't have formal higher education, were insistent on ours and were unwavering in their pursuit to provide my siblings and I with the best education. My father demanded excellence and his values are still the guiding principles of both my professional and private life.

My empathy for healthcare emanates from my longstanding battle with eczema. I have had chronic eczema since I was three years old and for most of my childhood it resulted in me being in and out of hospital, being seen by multiple dermatologists and at its peak, it confined me to my home as the flares would be weepy or blistered which are then susceptible to increased infection with the only comfort provided to me by the experts being that I would eventually outgrow it. My eczema was characterised by sores, reddening, swelling and crusting resulting in the extreme thinning and scaling of my skin which made other children and especially teachers in school treat me differently which my father didn't approve of. He would often take meetings at school

with teachers and sporting coaches to insist I be treated no different than any other scholar with a view by him that I was capable of doing and being anything I wanted to be. That was a defining moment in my life because I believed my father, despite the obvious external deficiencies, I believed my father. When I attained my provincial colours in softball and later my Master of Science Degree in Actuarial Science, all the things that seemed out of reach for someone who was as sickly and weak as I was, it dawned on me that most people have the heartache of proving people wrong as their burden while I have the pleasure of proving my father right as my burden. I didn't outgrow the eczema, but have learnt to manage it effectively and so my interest in healthcare was initially sparked by extensive research in the study of skin disorders.

**Please share some background about your previous work and your current role as principal officer?**

I worked in the insurance industry for 17 years, most of that time in short-term insurance. I evolved through various roles as a primary insurer, a reinsurer, a broker and a license provider for cell captives looking to carve out niche insurance products. My time in London was spent as a reinsurance broker looking after UK and European property and casualty accounts; it was during this time that I realised how unique South African citizens are and that because of this, when developing products, especially health and wellness products, how acute the customisation needs to be to ensure a good fit.

Upon returning from London, I made a deliberate shift to long-term insurance to realise the opportunity of participating in the creation of health, wellness and employee benefits. I worked in environments that enabled the creation of a suite of products that could be packaged to suit the varying needs of different employer groups. Retirement funds have always been a great vehicle through which to drive employee benefits, so the suite of products we would create would capitalise on that as well as offering a basic medical aid to complement the offering.

In my current role as principal officer of Barmed, I work with the board of trustees and the various governance

> **"I celebrate the true essence of being me in the workplace, and that includes celebrating my femininity and requiring a seat alongside my male counterparts at the table..."**

structures in place to oversee the scheme to ensure that we prioritise the health needs of our members by offering a non-differentiated plan across the entire workforce. This has the intended consequence of ensuring that the health and safety of employees are really at the forefront and their medical needs are met with high-quality services. We interact with our members through various communication portals and have recently introduced what we call 'a chatroom' where anything that is topical and trending is discussed in the presence of a subject matter expert. The Chatrooms interactive and empowering and, most importantly, leaves our members with the feeling of knowing more to inform any decision-making.

**What challenges have you experienced as a woman in the industry, and what did you do to overcome those challenges?**

I am acutely aware of the challenges many women face in male-dominated industries such as our own and how the dialogue of change needs to be maintained to ensure that gender-differentiating questions no longer precede or divert discussions. I consider myself fortunate that no challenge I have ever experienced in the industry or my career to date has been as a result of my gender; this is due in part to the fact that I do not characterise myself as 'a woman in the industry' but rather as 'an able and diligent contributor to the industry', making my gender irrelevant.

We often give ourselves the labels we resent being classified under. To experience challenges specifically as a woman would suggest that women are in some way frail and this is not the case. I made the decision as a graduate stepping into my first job 17 years ago that I would celebrate the true essence of being me in the workplace, and

that includes celebrating my femininity and requiring a seat alongside my male counterparts at the table, not because I am a woman, but because I am the best for the job at hand. Having said that, challenges are part of any environment where there are at least two individuals and the resolution of these has to be based on absolute facts, mutual respect and sometimes just letting some of it go.

**In your view, what is the role of funders in creating access to health services that are of good quality and affordable for the health citizen?**

The demographics of the country need to be the determining factor for the creation of and access to health services. South Africa is in some respects a very developed country, but many of its citizens have been left behind and often we design products with only the top 5% of the country in mind; these individuals are not representative of the majority of health citizens. In my Master's thesis I discussed in detail that R49.5 billion is collected by stokvels annually, coming from a population that is often described as not having a savings culture. These are trusted vehicles that funders should capitalise on to reach the majority of health citizens. Stokvels are, by all accounts, self-insurance initiatives similar to that of any first-party captive and I believe that great success would be derived from a partnership between funders and health citizens when using channels that are familiar and easy to understand.

**What has been a highlight for you this year in the healthcare industry?**

The successful rollout of the vaccination programme has without a doubt been the most noteworthy focus area for 2021. To be principal officer of a medical scheme at the height of a global pandemic has been a tremendous

# Trends & Opportunities

***What are some of the emerging trends that have had an impact on your members and scheme this year?***

1. Low-cost benefit options, efficiency discount models and medical insurance products are all topical for our members, especially the younger workforce where health needs are not as prevalent. I believe we will see more of these in the market in future, especially given the ailing economy where health citizens constantly ask themselves how they can supplement their disposable income.

2. Insurance products such as medical aid are a grudge purchase and the health citizen will want to see how they can minimise their expenditure on such products. This may greatly impact the future of comprehensive cover for our scheme and others as the industry becomes more competitive.

3. The rise of mobile practitioners who make house calls to patients in the comfort of their homes or places of work or those who wish to have telephonic consults. The inability to access hospitals and to some degree, limited access to medical doctors at the genesis of the COVID-19 pandemic contributed to the resurgence of mobile doctors, having seen it decrease to less than 1% in the 1980s.

honour, not just for me but for my peers at other medical schemes. We all had to roll up our sleeves and put initiatives in place that were focused on ensuring that we acted as an assistance vehicle to the National Department of Health and the government as a whole, providing the necessary facilities and financial support, and playing our part in mitigating the pandemic. The culmination of months of work coming together for a purpose bigger and greater than just your own scheme is meaningful and something we all should be proud of.

### What excites you the most about being principal officer of Barloworld Medical Scheme?

One of the core values of Barloworld as an organisation is diversity and inclusion, which then filter down to Barmed. For a closed scheme, this means that employee contributions result in benefits that are current, flexible and designed within the parameters of the regulatory environment within which we operate. It is exciting to work in a space as dynamic as that because it assists the board of trustees and myself to discharge our duties with a proper understanding of the needs of the members we serve, supported by the executive team of Barloworld and our administrator, Medscheme.

### What advice would you give to young men and women who aspire to become healthcare leaders?

Despite the evolution of healthcare, with the emergence of trends that appeal to a young audience such as wellness lifestyles, health consumables, fitness programmes and points tracking gadgets, it is still very much about servant leadership. One has to enter the healthcare industry primarily because one aspires to contribute to the wellness of people, systems, the environment and the planet at large. Healthcare is broad but as a leader in the industry, your role is about giving of your time for the benefit of others. As such, my advice to young men and women would be to enter the industry because of an inherent need to serve the communities within which they operate and with a desire to teach, uplift and give of themselves. We make important decisions about the lives of people, families, children....it has to be a calling.

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**Good health care is a long-term partnership between patients and their health care providers. In this partnership, the professional's expertise and perspective is essential but the patient's views are critically important. Our health care system's design and performance should incorporate what patients in all their diversity tell us about their experience and their specific outcomes.**

**In South Africa, "ask a friend or a family member" is often how we choose a doctor and judge a hospital. Although asking a friend can sometimes help, the measurement of patient experience and patient-reported outcomes is a better and more scalable method for assessing the performance of health care systems and is becoming the norm around the world.**

## WHAT'S THE SOLUTION?

'Voice of the Patient' (VoP) has been developed in South Africa to collect, report and learn from the experience and outcomes of the people that health care is meant to serve – patients. Measures of patient experience and patient-reported outcomes reflect the design and performance of health care systems.

VoP gives patients more of a voice in their care by making insights into 'what matters to you' available for assessment and improvement of care. It enables care that is more patient-centred and provides a tool for building a stronger health care system.


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VOP scientifically measures the results that matter to each patient by collecting information via a secure, convenient, and easy to use platform. Patients are asked condition-specific questions, using measurement instruments which have been localised to our unique context, to provide valuable insights into the care they receive.

The data collected is used to calculate patient reported outcome measures which correlate to clinical quality metrics. These metrics are combined with cost data to provide a holistic view. The information collected is then aggregated to protect the confidentiality of patients and reported back to health system managers in a user-friendly format to facilitate monitoring and decision making.

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# Our role in accelerating gender equality in healthcare

*Implementable instruments that will accelerate gender equality and proactively create opportunities for the development and upskilling of women are the responsibility of every business and every person in a leadership position today*

Gender equality is a critical factor to be considered by all of us in leadership and in any setting. We have had many conversations, but there have been few implementation plans and monitoring tools.

We need measurable instruments to ensure the acceleration of gender equality. One could even consider making it a key performance indicator for decision-makers, particularly in those organisations that opt to deal with criticism or pay penalties instead of promoting gender equality. We already know some causes of inequality; these have been aired adequately in different documents and forums.

Our role is to come up with implementable instruments that will accelerate gender equality. Women in leadership must ensure that women are appointed to decision-making positions at equal pay with their male counterparts. We have too many instances of women appointed in critical roles at reduced pay; this cannot continue as it discourages willingness to take up these roles. Over and above taking lower salaries, there are unfair expectations from everyone on the incumbents; the current ploy is to put pressure on these women leaders so that they give up or else are labelled corrupt or incompetent.

## CHALLENGES TO OVERCOME

Policies that exclude women or make it difficult for women to take up senior demanding jobs should be reviewed. The COVID-19 pandemic has taught us that employees can work from home and be productive, particularly when clear performance outcomes are in place and they are evaluated frequently with objective feedback. Although it has become very challenging for women in leadership to convince their masters to adjust policies or to encourage women to take up leadership positions due to current volatile working environments, it needs bravery and a thick skin to persuade certain commentators to treat employees equally.

The pandemic also added to the unpaid care work of women and loss of jobs for many young girls and women, thus widening the equality gap.

Encouraging women to acquire qualifications, but not providing experience, is a big challenge that must be addressed. Once these women gain formal qualifications, they are not considered for positions because of excuses with regard to lack of experience. Organisations must be prepared to bring in a pool of women for coach-

> **“Our joint role in healthcare is to create opportunities for women for development and upskilling if we want accelerated gender equality.”**

ing and mentoring, and give them an opportunity to learn on the job. None of us in current leadership positions occupied them with experience from day one; we must have leaders who are prepared to allow others to learn under their supervision.

The grass that we all see as greener on the other side was watered and maintained by someone. Gone are the days of looking for skilled and experienced people when we are not prepared to be the ones supporting others to acquire the necessary experience.

There is growing unwillingness to allow a margin of error even in ordinary decision-making that does not affect corporates; this seems only to affect women. Many of our counterparts have made detrimental decisions and no one made an issue of it; we must desist from discouraging women using tactics of this nature.

A working environment must be welcoming to the mental health of women. It is generally accepted and understood that most households are managed by women. The challenges brought about by the pandemic, burden of diseases, abuse of/addiction to alcohol and drugs (in children), violence against women and children mostly affect women. It is difficult for women to perform at optimal levels even if they want to.

Making working environments and conditions bearable will go a long way toward ensuring that women are evaluated fairly.

Any form of violence must be eradicated. Some workplaces are notorious for sexual harassment and inadequate attention is paid to totally removing such practices. Young girls and women feel obliged to succumb to some men who pressure them to 'buy' positions and keep quiet about it. Instead of dealing with perpetrators, companies allow these men to move on to another organisation and continue their evil practices.

We all have a moral obligation to support women in all their positive endeavours. No matter how difficult the situation is, women must support each other if we want to accelerate gender equality. Together we can dispel the misconception that women are not good or strong leaders. Polmed employs a majority of women in decision-making positions and continues to identify women for key positions.

Our joint role in healthcare is to create opportunities for women for development and upskilling if we want accelerated gender equality. ■

**MS NEO KHAOUE**
*BHF Chairperson and*
*Principal Officer, Polmed*

# Beyond tools

## Innovative approaches to influence progress towards universal health coverage

As the world continues to learn from lessons brought about by the pandemic, our collective dependency on technology is increasing in every sector, including global health. When considering opportunities and solutions addressing population health matters, few would argue to exclude technology.

In the midst of growth, we must not lose sight of the innovation we truly need. To ensure that technology helps the world achieve universal health coverage (UHC) we need to learn to interact with technology to alleviate the burden of disease currently being carried by patients and the general public. Conversely, learning to utilise existing technology will lead to a better understanding of the needs of patients, protecting the privacy of patients and the public at large, establishing policies that promote equitable access to quality services, and ensuring the use of data for decision-making.

### UNDERSTANDING NEEDS

Interacting with technology will require prioritising solutions that help with understanding what patients need, and determining how they can access services that transform their lives.

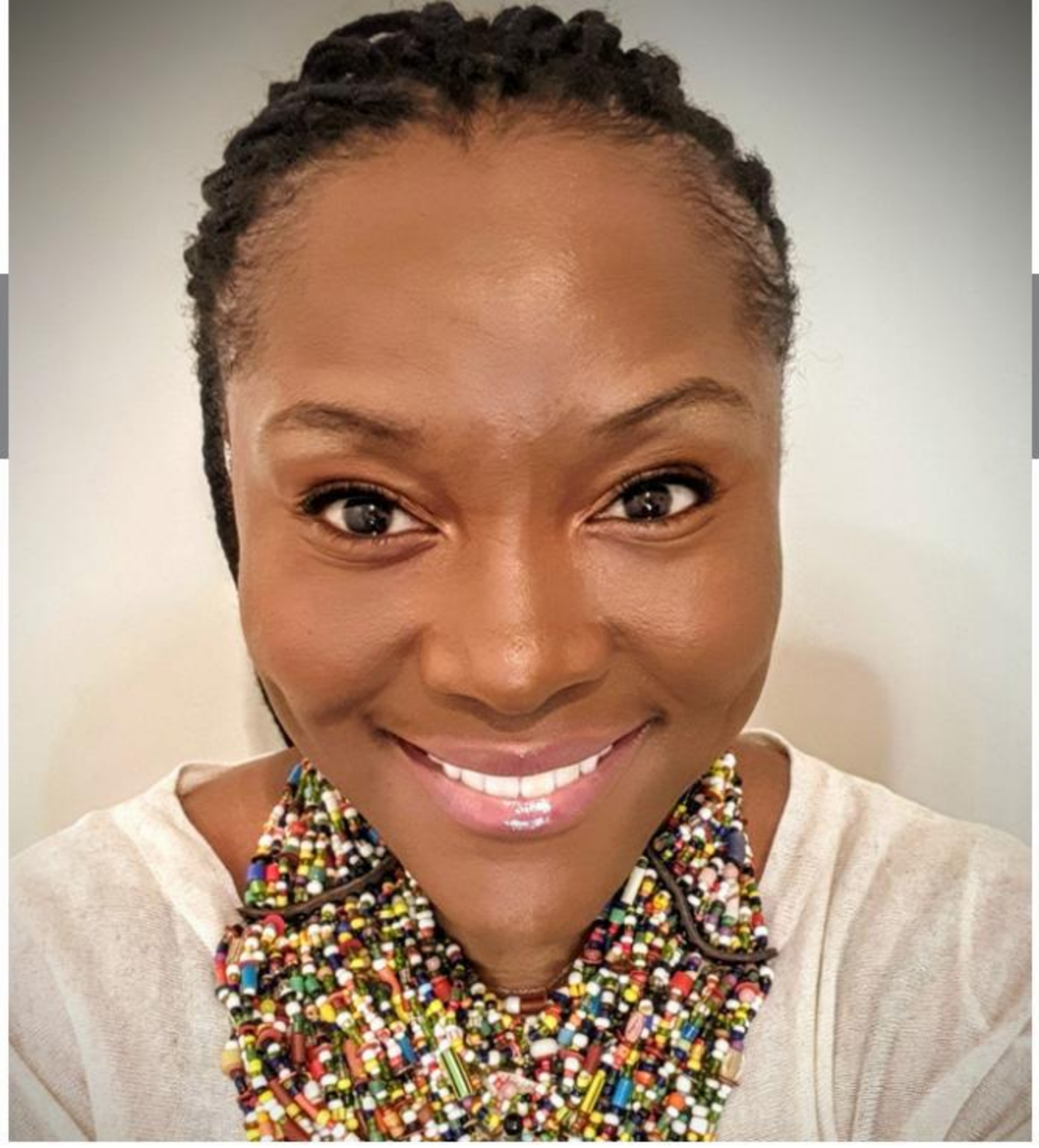
Many examples and narratives have flooded our inboxes throughout this year alone, addressing the numerous uses of technology before and during the pandemic. These examples of automated solutions include telemedicine, contact tracing applications, supply chain management software, mobile testing sites and laboratories, machine-learning and artificial intelligence, and the use of geographical information systems.

These technologies have all enhanced our collective ability to manage challenging global health situations. However, there has been a remarkable lack of patient stories to confirm the impact of said solutions. The complete narrative of the value and impact of these solutions must also include reports from patients and the public who benefited from them. Otherwise, decisions around technology will continue to be made with incomplete narratives.

### PROTECTING PRIVACY

In discussing the potential of new and existing technologies, we cannot ignore increased concerns about data privacy and calls for fit-to-purpose regulations. Effective use of innovations and technology requires a deeper consideration of its positive impacts and significant efforts to mitigate adverse effects. The rapid adoption of technology-based solutions calls for an update in processes and policies to ensure that equitable access to quality health services does not also lead to compro-

> **“...we need to learn to interact with technology to alleviate the burden of disease currently being carried by patients and the general public.”**



mised patient privacy. Protecting data as we work to close the gap between innovation and policies will assist in maintaining public trust.

## LESSENING THE DIGITAL DIVIDE, INCREASING CAPACITY

Technology advances are continuing, and adopting new and existing technologies will become a prerequisite for the health sector's resilience. However, to fully benefit from available active solutions, processes and procedures in a manner that leads to achieving UHC, there must be full commitment from policymakers to ensuring the responsible and fair use of current technologies, leading to targeted development and scaling of technologies that truly improve the quality of people's lives, and lessen rather than increase the digital divide.

## USING QUALITY DATA FOR DECISION-MAKING

Practitioners', researchers', clinicians' and the general public's education on data use continues to increase. Even with a shortage of policies to support the numerous advancements, mass data collection efforts in global health continue. These data have helped determine approaches to addressing the pandemic and assessing the resilience of health systems worldwide. They can also help policymakers understand what is required to achieve equitable access to life-saving technologies. These times require those responsible for the health of their populations to use available data to determine which technologies and innovations will ensure they reach UHC. In addition, data can assist with determining what the public requires of its health system. They can also help identify gaps and update processes and policies that will lead to equitable access to quality health services.

Advances in technology are continuing as the global health community challenges itself to identify new ways to leverage existing technologies and ensure that new technologies genuinely address the needs of populations worldwide.

However, to fully benefit from available effective solutions, processes and procedures in a manner that leads to achieving UHC, policymakers must join the innovation movement. In addition, policymakers must commit more to understanding the value of using available technologies, decreasing the digital divide, protecting the public's privacy and facilitating collaboration across sectors.

Achieving UHC with the help of technology is only possible through appropriate policies. These policies must also ensure responsible and equitable use of current technologies. ■

**MS HUGUETTE DIAKABANA**

*Co-Chair, World Health Organization Digital Health Technical Advisory Group; Harvard Medical Schools Executive Teaching Program*

# Healthcare fraud, waste and abuse – a case for collaboration

*The complexity and breath of healthcare FWA make it imperative for all affected stakeholders to work together, share information and data to correctly identify instances of FWA, and make efficient use of limited resources.*

Discussions on healthcare fraud, waste and abuse (FWA) have taken an unfortunate turn, which has pitted stakeholders in the healthcare industry against one another. This has made responses to this scourge very difficult and while all this is happening medical scheme beneficiaries are the ones that ultimately pay the price in the form of unsustainable contribution increases as well as benefit reductions.

Health service providers (HSPs) have been placed at the centre of FWA, but while they may play a significant role, they are not the only ones responsible. Administrative staff at both medical schemes and HSPs are also involved, as are scheme beneficiaries. It's also important to acknowledge that only a very small proportion of HSPs are involved in FWA, probably less than 5%.

One needs to take a step back to fully understand why the healthcare industry is confronted with FWA. One must first acknowledge the complexity of the medical schemes industry. There are numerous benefit options that HSPs must grapple with; moreover the benefit option content is often presented in a complex way. The coding that is vital for submitting claims is not standardised across all schemes. This fragmented approach is further compounded by how schemes identify and investigate instances of FWA. Differing and inconsistent approaches make it more difficult for HSPs to respond to alleged instances of FWA.

On the funder side, when instances of FWA are identified there is very little support in terms of prosecution and consequent management available to mitigate the losses suffered by schemes. Schemes have had to innovate to ensure that beneficiaries' funds are protected. The responses by schemes have not been received well by HSPs. The sentiments of the provider community are captured in the section 59 investigation interim report. Indeed, the lack of regulatory oversight in FWA mitigation has made the situation worse. A consistent coding structure would help; a standardised tariff structure and a simpler and standardised benefit design would make the claiming process so much easier for providers.

Even better would be alternative reimbursement models that incentivise good care for patients while placing less focus on billing and coding. Regulatory support in dealing with alleged FWA has also been lacking; hence funders have had to devise methods of limiting losses on their own.

There is no firm understanding of the true cost of healthcare FWA. Perhaps if all stakeholders appreciated the true cost a multi-stakeholder response approach would be easier to implement. Industry-wide reports on losses should be instituted on an annual basis. This will help inform stakeholders of the urgent need for an appropriate response. Consequent

management may also be easier to enforce.

Collaboration is key to fighting FWA in the healthcare sector. It manifests in many forms, including false claims, overbilling for services, coding abuse, fake professional reports and abuse of privileges (e.g. providers employed by the state moonlighting in the private sector). As a result, FWA losses affect many stakeholders, not just medical schemes; anyone who pays for health services is affected. This includes the state through bodies like the Road Accident Fund, the Compensation Fund and provincial health departments. Even employers from many industries are impacted through lost man-hours, specifically in the form of fake sick leave notes being issued to employees.

The complexity and breath of healthcare FWA make it imperative for all affected stakeholders to work together. There is a need to standardise approaches and responses. There is also a need to share information and data to correctly identify instances of FWA. The resources (both financial and human) that must be employed to mitigate losses are enormous and the industry has a huge resource gap. This could be best addressed by the various stakeholders working together to efficiently use the limited resources available. ■

## THE HFMU ONLINE PORTAL

The online portal of the BHF Healthcare Forensics Management Unit (HFMU) has over 100 participants representing various organisations. Members have shared over 400 cases of investigations conducted in respect of FWA in the portal since its relaunch in 2018. The HFMU has expanded beyond South Africa and includes participants from Lesotho, Namibia and Zimbabwe. The portal has been further developed for members to share and analyse their own data, in efforts to mitigate risk exposure.

https://www.bhfportal.co.za

**CHARLTON MUROVE**
*Head of Research at the Board of Healthcare Funders*

# SOUTH AFRICA'S YOUTH

## is getting more sick, according to AfroCentric's latest numbers

Ahmed Banderker, CEO of SA's most diversified, black-owned health group, AfroCentric, takes a look at the conditions plaguing our young people, and what we can do about them.

South African youth (individuals aged 18 to 34) make up a third of our people. With an estimated population of just under 60 million, we're talking about 20 million lives. We are – by nature and by numbers – a "young country". It stands to reason, then, that prioritising youth development is not only a social imperative, but an economic one for our country.

Being in the health industry, we started to ask ourselves what we could see from the vast amount of data we have on South Africans' health, and particularly, youngsters' health.

> "Over the past nine years, the category with the largest increase in admission numbers is mental health admissions, which has increased by 71% since 2011.*"

Are South African youth becoming sicker or healthier? In short, no to the latter. Our data in fact was indicative of a disconcerting trend – youth health is on the decline, with almost every graph we have on hand showing increasing numbers associated with chronic illnesses.

Let us pause to consider the statistics:

- **Chronic disease:** Over the past 10 years, the proportion of young people with 1 or more chronic diseases has more than doubled, from 2.5% in 2011 to 5.1% in 2020.
- **Asthma and allergies:** Our youth are potentially more afflicted by asthma and allergy related conditions, which make up 49% of all youth chronic registrations in 2020. Since 2011, the prevalence of these 2 conditions increased by 87%:
- **Mental health:** Of the three conditions that showed the largest percentage increase in prevalence since 2011, two of these relate to mental health – bipolar mood disorder, which showed a 214% increase in prevalence among the youth, and depression, which saw a 130% increase in prevalence among young people.
- Over the past nine years, the category with the largest increase in admission numbers is mental health admissions, which has increased by 71% since 2011.*

**Note: 2020 was excluded due to the drop in non-emergency elective admissions experienced across the industry as a result of Covid-19.*

Our statistics paint a vivid picture of a youth in crisis: not only do we have an unemployment problem to worry about, we potentially have future health crises brewing too.

Unfortunately, as concerning as this picture is, it is not altogether surprising, given the rise in prevalence of sedentary lifestyles within our world. Are the rises in asthma and allergy conditions perhaps attributable to environmental issues? Issues around global warming, climate change and environmental degradation are making frequent appearances in public discourse.

One study suggests that air pollution can have a greater effect on health under extreme weather conditions. And in a country where temperatures are predicted to rise dramatically due to climate change and growing water scarcity in the next few decades, South Africa should take heed. Another study published in the SA Journal for Child Health (SAJCH) conducted in Durban, for example, reached the conclusion that children living in areas where there is a high level of outdoor air pollution can present more asthmatic symptoms than children in other areas. This is surely no coincidence.

**THE TOP 5 HOSPITAL ADMISSION CATEGORIES AMONG YOUTH IN 2019 WERE FOR:**

- intestinal infectious diseases (17% of all youth admissions),
- tonsil/adenoid procedures (12% of all youth admissions),
- pneumonia (12% of all youth admissions),
- caesarean deliveries (11% of all youth admissions), and
- mental health admissions (11% of all youth admissions).

The numbers around mental health are alarming too. An increasing number of celebrities and well-known public figures talking publicly about their mental health has done wonders to raise awareness of illnesses such as depression, bipolar mood disorder and generalised anxiety disorder.

Not only can we attribute the rise in mental health issues to this awareness drive, but we look to external stressors, such as the unprecedented level of youth unemployment in the country, as a potential cause. And, in the context of the pandemic, mental health may as well be another silent pandemic that is crippling us, as almost every metric shows a significant rise in mental health issues.

Sadly, this is and was to be expected. Uncertainties around one's Covid

status, the social and economic pressures caused by the national lockdown, and the increased mortality rate and loss of loved ones have all contributed to a more stressed, more depressed youth. Although the trauma of losing a loved one is tough to deal with, I believe it is even harder and more traumatic in a Covid-19 world, where many people cannot observe their preferred or traditional burial rights because of the lockdowns, and have had to grieve in isolation. Support from friends, family and the community has been limited to virtual or telephonic support.

Dr Victor Tseng, a notable American pulmonary and critical care physician, who specialises in Covid-19, has said that the predicted direct and indirect impacts of Covid-19 on healthcare systems will be "profound and sustained". Particularly, he foresees a sustained period related to mental illness, burnout and economic injury. These are the kind of challenges that health providers will need to focus on in the post-Covid world.

While mental health issues and possible environmental illnesses may be avoidable, type 2 diabetes is directly related to lifestyle. An increase in this shows that South African youth are not making the healthiest choices around their health. We look to increased urbanisation as a possible cause for the rise in the prevalence of sedentary living.

Today's youth is desk- or couch-bound, living in an increasingly digitised reality where aspects like physical exercise and healthy dietary choices play second fiddle to other concerns. And, for most, the pandemic has just exacerbated this already existing trend.

As advocates for better health, we have a mammoth task ahead of us. We need to prioritise ways in which we can motivate our young people to get outdoors, get their bodies moving and their hearts pumping.

Now, more than ever when screen time is taking precedence over self-care time, we must intervene. If we do not intervene now and change behaviours, South Africa will not be improving its burden of disease.

The decline in health among South African youth of course has a direct impact on the medical aid sector. Our membership trends suggest that affordability has been the main determinant of the choices that young people make around medical cover.

On average, adults below the age of 34 apply for basic hospital plans or plans that do not cover day-to-day expenses. But the approach of keeping one's medical aid contribution as low as possible has a downside: costly hospital admissions as a result of poor health maintenance (which correlates with a lack of access to day-to-day benefits) is one such factor.

For medical aid schemes, innovative product designs around primary care are the key to providing a viable and sustainable way forward. For society at large, a fuller reckoning is needed.

If the pandemic has taught us anything in the health sector, it's that youth issues are not just of national concern. Members of the South African youth are global citizens. Their health and wellbeing are therefore of global concern. The solution, it seems, must come from the collective. ■

# What does the reset button do FOR MEDICAL SCHEME MEMBERS?

By Josua Joubert
CEO AND PRINCIPAL OFFICER OF COMPCARE MEDICAL SCHEME

*A total reset is already upon us with dramatic changes not only in the expectations of consumers, but also their experiences. Members are stressed, they are taking strain – medical schemes need to be prepared. We need to be ready to show up.*

To be 'in survival mode' is no way to live. Yet looking back over the past 18 months and longer, our industry has perhaps become settled into a reactive state. Yes, we are all part of a system that is not without challenges. Healthcare costs that escalate beyond the rate of inflation, for example, can be a bitter pill to swallow. The implementation of NHI and the role we, the private sector, will play remains somewhat of a question mark. And dare I even mention the ongoing pandemic?

But it is our own proactive behaviour that will determine our survival and it is not safe to assume that South Africans will be able to purchase private healthcare indefinitely. A total reset is already upon us with dramatic changes not only in the expectations of consumers, but also their experiences.

## BACK TO THE DRAWING BOARD

So what is the ideal offering, the one that is not only attractive but also sustainable? Going back to the drawing board means reassessing what matters most. In the medical schemes context, value equates to meaningful benefits that wherever possible provide support without requiring members to dip into their own pockets.

Realistically, so many healthcare consumers avoid getting the care they need because of the financial implications. Take mental health, for example. We know that this is one of the most underfunded areas in global healthcare and the average medical scheme in South Africa has poor psychosocial benefits. This simply cannot continue.

## MENTAL HEALTH MATTERS

Before COVID-19 the South African Depression and Anxiety Group (SADAG) reported taking around 600 calls for help per day. By September this year that number had increased sharply to 2 200 calls daily.

Equally alarming are figures released by UNICEF in its 2021 report on the mental health of children, adolescents and their caregivers. The report cites a survey, which found that one out of



# RESET BUTTON FOR MEDICAL SCHEMES

**Josua Joubert**
*Chief Executive and Principal Officer of CompCare Medical Scheme*

every five people aged 15-24 years expressed regular feelings of depression.

Whether purchasing medical scheme membership as a family or as an individual, tangible mental health benefits, such as unlimited access to a 24/7 professional helpline with referrals for one-on-one counselling when required, should not be restricted to certain options only.

This is the kind of benefit that all members on a scheme should be able to benefit from. Taking things one step further: applying a child rate on all options until the age of 27 for students and those who are financially dependent can provide a much-needed lifeline.

## DELAYED CARE

Also under consideration is the impending wave of devastating late diagnoses that will likely be the result of so many people having delayed preventative check-ups, in an effort both to avoid the doctor's office during COVID and reduce expenses.

An unlimited oncology programme is essential but simply not enough – it is the scheme that pays for preventative checks from risk rather than day-to-day benefits that is giving members real support in the here and now.

## FAMILY BENEFITS

So many members' worlds have been turned upside down with working from home, attending classes via Zoom and generally having to find a way to reset their lifestyles.

Active support in regaining and maintaining physical health with access to a fitness and nutritional programme, as well as access to a biokineticist and registered dietitian, can go a long way in helping the stressed and strained individual to restore balance.

Child benefits that include an additional emergency room visit and unlimited GP visits for those under the age of six with the option of an occupational therapy assessment, exercise prescription programme and healthy eating plan can provide just the boost that a tired young family needs.

## FINANCIAL STABILITY

And of course, the money matters. Yes, one can choose to implement contribution increases gradually or to defer them to later in the cycle. Kicking the can down the road is a strategy. The question is whether it's the right one for the medical scheme member.

Ultimately, it is first and foremost the job of the medical scheme to ensure that all members have access to the care they need whenever they may need it. Members are stressed, they are taking strain – medical schemes need to be prepared. We need to be ready to show up.

# LEST WE FORGET the lessons of earlier pandemics

*We need to bring people along. We should never forget that ultimately, healthcare provision is about people, their needs and expectations.*

By Dr Katlego Mothudi
MANAGING DIRECTOR, BHF

I only realised recently that I had known of the 1918 Spanish flu for a long time. It was imprinted on my mind unknowingly by my grandmother. When referring to when her younger brother was born, she would always say that it was during the time of the 'three-day disease' ('Bolwetse ba drie-dag' – a combination Setswana and Afrikaans phrase). For many others, it is ironically thought of as the 'forgotten pandemic' as in 1918 there was a whole lot more happening than a disease that would take a person's life within 1-3 days of being infected. There was a world war in progress; cholera, diphtheria, typhoid and yellow fever also made an appearance at that time. The reported global mortality associated with the Spanish flu was estimated to be between 17 and 50 million over the four waves that took place between 1918 and 1920.

In November 2021, South Africa found itself between the third and anticipated fourth wave of the pandemic. The country has already reported close to 90 000 deaths linked to COVID-19 and, as part of the global movement, is scrambling to vaccinate as many of its citizens as quickly as possible to limit the devastation already seen in the preceding three waves.

As with many new events, there has been a lot to learn. We have already expanded our vocabulary with new phrases like 'flattening the curve', 'super-spreader', 'social distancing' and 'vaccine hesitancy'. The most significant lessons, though, should be those that lead to improvement of our healthcare system. For South Africa, the crisis could not have been more opportune as we are currently trying to reconfigure our healthcare system.

So, what are we learning?

Healthcare can make or break the economy and the country; we therefore have no choice but to fix our healthcare system. The Health Market Inquiry confirmed that private healthcare is becoming progressively more unaffordable and other commentary confirms that the country's institutional frameworks perpetuate inequality, rather than address it. The healthcare budgetary allocation, while it has been gradually decreasing annually, is not based on need and has not been geared towards addressing existing inequalities. There is therefore an even more urgent need to right the healthcare system and have a positive impact on both country and economy.

The state cannot do this alone. It does not have unlimited resources; it can provide services only to the extent it can afford them. The private sector does, however, have assets; while these are not transferable to the state, they can be used to augment state-initiated projects that are to the benefit of the health citizen. The state should view the private sector as its asset, and not a competitor or inhibitor. Essentially, we need a unified industry to share our healthcare responsibilities.

Healthcare provision can be expensive; we therefore need adequate resources. At the centre of the definition of Universal Health Coverage (UHC) is the need for financial protection for the health citizen.

**Dr Katlego Mothudi**
*Managing Director, BHF*

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place to move forward. A health system has a lot of moving parts, and some may take a considerable time to put in place. We may struggle for a while with issues pertaining to infrastructure, human resources and finances. While managing the legal aspects, we must pay equal attention to all other elements necessary for the successful implementation of healthcare reform and the eventual realisation of UHC.

Technology and data science are key tools in modern-day reform. We must formalise processes for technology integration to respond to the healthcare needs of the population. We need to be agile and to strive for quick collection and sharing of information to optimise population health management

Good governance is crucial. The WHO lists leadership and governance as one of the six pillars essential for a good healthcare system. Accountability of appointed officials needs to be ensured and sufficient controls, checks and balances should be in place to safeguard the rights of the health citizen and integrity of the system. The twin peaks model of governance may be considered and implemented in any institution that wants to limit the risk of fraud and corruption. Central to this is efficient deployment and safeguarding of resources, as well as consideration of the health citizen's needs.

The COVID-19 pandemic must not be remembered for vaccine hesitancy or worse, become the second forgotten pandemic. It needs to be the cornerstone of what we are learning about our envisaged healthcare reform. ■

It goes without saying that we need to have adequate resources to provide them with the high-quality healthcare they need. The costs are in addition escalated by increasing reliance on technology, which has a massive influence on health delivery systems and their advancement. We need to remember though that the needs of the health citizen are determined primarily by their disease burden as well as by the service delivery elements essential to ensure that the customers are treated fairly. It won't make sense to strive for financial protection while the benefits that are on offer do not satisfy the health citizen's urgent needs.

We need to bring people along. We should never forget that ultimately, healthcare provision is about people, their needs and expectations. It is a priority to empower the health citizen and listen to their needs, rather than satisfy what may seem correct from a policy or political point of view. While it may be frustrating from a professional point of view to address concepts like vaccine hesitancy and argue technical concepts from a lay perspective, we still need to listen more and give out information that is relevant. Uppermost is the provision of quality healthcare that has outcomes consistent with the population's expectations and the needs of a receptive end-user.

Sometimes when we need to move fast, we must navigate slowly. Most health systems take a long time to be implemented. We need to ensure that we have most of the right things in

# Collaborative, techno-savvy healthcare building blocks

The road to an effective and inclusive South African healthcare industry is ever evolving. This evolution is largely driven by a plethora of shifts that the industry must contend with. Legislative changes, a rapidly transforming regulatory framework, policy regime, digitisation, the Internet of Medical Things (IoMT), telehealth and the imminent rollout of National Health Insurance are all at the forefront of these emerging trends.

Despite the devastating effect COVID-19 continues to have on our people, the pandemic has helped the industry to regroup with a renewed focus on accelerating universal healthcare implementation.

On 6 October 2021, Momentum Health Solutions partnered with various key business leaders and major labour unions, including NEHAWU, to support an improved healthcare system for South Africa. The objective of this alliance is to bring together a leading group of stakeholders who have the positive intent and skills required to solve the country's unique healthcare challenges, and to smooth the path to a better future.

The IoMT comprises the network of internet-connected medical devices, hardware infrastructure and software applications used to connect healthcare information technology. It brings with it the ability to create an ecosystem where wearable and other medical devices are interconnected. This allows for remote patient monitoring and telehealth, as well as analysis and storage of data. It also plays a pivotal role in helping with disease prevention and monitoring and controlling patients with chronic illnesses.

The runaway success of Hello Doctor (HD) in some of the health facilities where it was piloted has helped to demonstrate the full might of telehealth. By deploying the HD teletriage tool, we have seen increased utilisation of the app, with a concomitant reduction of up to 60% in terms of unnecessary consultations, thereby improving efficiencies at the index clinics.

Data has taken centre stage and is now considered the new currency. Given trends in data warehousing, interrogation and business intelligence tools, the need for interoperability of all health platforms cannot be overemphasised. The advent of data analytics and artificial intelligence has served as a catalyst in support of a centralised industry database with interoperability that serves as the confluence. It will eradicate duplication, reduce healthcare costs and bolster eHealth initiatives like electronic health records.

The aforementioned trends will herald an era that will most likely turn the industry on its axis, paving the way to better health for more at lower cost.

**Tiego Malibe**

*Head of Clients Insights & Service Monitoring at Metropolitan Health*

ADVERTORIAL

# The National Cancer Campaign

## *Developing strategies to reduce South Africa's cancer burden*

**DR MANALA MAKUA**
*Chief Director: Women, Maternal and Reproductive Health*

Breast and cervical cancer policies were approved in 2017; this came as an acknowledgement that these two cancers had been two of the most common cancers in South Africa for more than four decades. In 2014, the National Cancer Registry reported 8230 cases of breast cancer and 5735 cases of cervical cancer. Both these cancers have a high age-standardised of 33.3 (breast) and 22.5 (cervical) per 100 000 populations. While there is no documented record of treatment outcomes for these cancers it is estimated that the case fatality rates are high.[1,2]

In October 2018, the Department of Health launched the National Cancer Campaign to respond to the high cancer incidence in South Africa. The intention was to accelerate the implementation of policies and related guidelines, and to develop multifaceted, comprehensive and inclusive strategies to reduce the country's cancer burden. Different stakeholders were invited to participate in the campaign in a collaborative and complementary manner to maximise the country's limited resources.

One of the stakeholders is AstraZeneca with its Phakamisa project. Phakamisa was conceptualised prior to the National Cancer Campaign as a patient navigation project mainly supporting NGOs in recruiting and training community-based workers to support patients diagnosed with cancer through their cancer journey.

As the five campaign objectives were extensively shared, the Phakamisa project was re-conceptualised to respond to most of these. The focus was also on alignment with breast and cervical cancer policies. The project assists the Department in creating data collection applications to document the signs and symptoms that patients present with during their initial contact with healthcare providers, e.g. community healthcare workers or primary care nurses. Data are collected at primary level and analysed to assess community levels of knowledge of the early warning signs of both breast and cervical cancer and patients' health-seeking behaviour.

This is to address the challenges related to patients presenting late to healthcare facilities. Late presentation has an impact on complexity of treatment plans, poor prognosis and compromised quality of life for the patient and a financial burden for the family. The focus is on community healthcare workers' and primary health nurses' capacity-building on how to educate, communicate and document essential knowledge of community members and patients in primary healthcare facilities. The initiative is being piloted at Steve Biko Academic Hospital and its regional, district and primary facilities.

Phakamisa will support the advanced training of oncology nurses with a breast care course. The course will help to support primary care nurses to ensure prompt referral of patients with breast conditions.

### OBJECTIVES OF THE CAMPAIGN

- To create awareness of cancer and other related non- communicable diseases
- To increase access by early detection through screening services for breast and cervical cancer
- To improve the linkages to treatment and care by improving the skills of healthcare workers
- To increase support to patients already diagnosed with cancer through collaboration with stakeholders and civil society organisations
- To strengthen health systems by establishing regional centres for oncology services.

These nurses will facilitate the establishment of regional hospital breast care centres as recommended in the breast cancer policy. This will assist in proper triaging of patients with breast conditions to minimise delays in transfer to the next level of care.

Most regional health facilities do not have oncologists or surgeons with a focused interest in breast surgery. Patients with breast conditions are all referred to tertiary institutions for further management, resulting in delayed access to services for those with breast cancer. Oncology-trained nurses from both regional and tertiary hospitals will create a seamless referral pathway for women with breast cancer, thus reducing waiting times. The six-month course began on 1 September 2021, with a cohort of 30 nurses recruited from six provinces, North-West, Mpumalanga, KZN, Eastern Cape, Gauteng and Western Cape.

The Provincial Departments of Health (NW, WC, EC, KZN & MP) identified the participants in the course. The National Department of Health facilitated the initial Sexual and Reproductive Health (SRH) online training (module 1, module 10 and module 12). Module 1 is an overview of the SRH) curriculum; this is to educate people on the components of SRH, of which breast and cervical cancer are at par. Module 10 covers genetics as this is closely related to cancer development and Module 12 covers reproductive cancers.

On completion, Phakamisa will support advanced training on breast care to be offered in collaboration with Stellenbosch University. The training comprises one month of self-learning, a week of skills demonstration and four months of mentorship to allow for competence-based outcomes.

The campaign has the following stakeholders, among others:

- National Department of Health (Maternal, Child, & Women's Health)
- National Department of Health (non-communicable diseases)
- Provincial Department of Health (Maternal, Child, and Women's Health managers)
- Tertiary institutions providing breast and cervical cancer treatment
- NGOs supporting the National Cancer Campaign

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PHAKAMISA
An AstraZeneca Access to Healthcare Initiative

# AstraZeneca Phakamisa Programme

**Phakamisa** *v/t [phaga'mi:sa]: IsiZulu for elevate, lift, raise, uplift, upliftment*

## Our vision of tomorrow inspires our actions of today

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Our ambition is to improve access to health and standards of care for patients, with a current focus on breast and prostate cancer.

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# BENEFIT ENHANCEMENTS and digital innovations

*Technological innovations to help medical schemes protect the health of their beneficiaries*

By Leo Dlamini
BESTMED MEDICAL SCHEME

The COVID-19 pandemic has altered the landscape of many industries, including medical schemes. In response, medical schemes have had to consider technological innovations to help protect the health of their beneficiaries during healthcare consultations and various other interventions, including assistance with depression and anxiety.

## CLAIMS RATIO TRENDS

The Council for Medical Schemes (CMS) requires all South African medical schemes to have a minimum reserve level of 25% to ensure solvency in the event of a sudden and/or unexpected increase in claims.

For the 2020 financial year, most schemes recorded lower claims ratios, well below the industry average of the prior five years, and therefore better financial results for the year.

Medical schemes have had to consider the best ways in which to use their reserves to meet their beneficiaries' healthcare, as well as financial, needs. An important consideration for many schemes is that the buffers accumulated until 2020 would most probably be sufficient to cater for near-term risks; however, over the long term economic challenges consequent on the COVID-19 pandemic may strain an already stagnant industry.

As at 31 December 2019, Bestmed exceeded this requirement with a solvency ratio of 35.4% and remained financially stable with a claims ratio of 86.8%. As at 31 December 2020, Bestmed had again exceeded the CMS' requirement with a solvency ratio of 47.3%. The claims ratio was 76.7%, due to a decline in claims for general and elective procedures.

During 2021, Bestmed experienced an increase in claims, resulting in a higher claims ratio. Leo Dlamini, CEO and PO of Bestmed, states: "The scheme is seeing an increase in the utilisation of funds for general and elective procedures similar to, if not more in certain instances than, that of the pre-COVID-19 period. The claims trend that we've seen over the last four months is likely to continue, thereby normalising the utilisation of funds."

## AVERAGE ANNUAL INCREASES AND BENEFIT ENHANCEMENTS

Medical schemes need to consider the cost of COVID-19 over and above general claims, which could have a significant impact on their contributions versus utilisation ratio. If claims begin to exceed contributions, a healthy reserve pool is essential for a scheme to absorb higher claims.

According to the South African Reserve Bank, Bestmed is one of few large schemes that have kept their annual increase below 5%. Bestmed's average weighted contribution increase for 2022 is 3.9% across all benefit options. The scheme has managed to keep increases low not only because the claims ratio for 2020 was low, but because the scheme already had healthy reserves prior to the COVID-19 pandemic and its administration costs have been managed prudently.

Bestmed has also increased its benefit limits for 2022 more than its contribution increases across all options. Limits and sub-limits were increased by 4.2% across all benefit options. This is the second year in which the benefit limit increase exceeds the average contribution increase for the year.

## DIGITAL PLATFORMS

The medical aid industry has been expected to spearhead innovative solutions to help contain the COVID-19 pandemic and ensure that members have safe access to healthcare providers. Therefore, integrated platforms for video consultations, specialist referrals and paperless scripts have gained traction.

Bestmed was the first medical scheme to partner with a digital healthcare innovator to bring general practitioners (GPs), specialists and healthcare providers a selection of functionalities to maximise service efficiency and enhance patients' medical outcomes. This unique partnership makes a specialist service provider network available to GPs for easy referrals via iCanRefer. It also provides both GPs and specialists with the iCanScript digital health solution and virtual consultations are available to network doctors via CLICKDOC Video Consultation.

Bestmed remains committed to ensuring that healthcare practitioners are equipped with the latest in technology to provide efficient, cost-effective and Personally Yours services to its beneficiaries.

## MENTAL HEALTH CONCERNS

According to the South African Depression and Anxiety Group (SADAG), an average of one in 10 people suffers from major depression at some point in life. However, only 25% of those who suffer from depression seek help.

There has been a rise in depression and anxiety during the COVID-19 pandemic due to several factors, including isolation, health concerns and economic instability. Medical schemes, such as Bestmed, have taken their beneficiaries' mental healthcare needs into consideration during this difficult time.

From 2022, approved medicine claims for major depression will continue to be funded from scheme risk once the non-CDL (Chronic Disease List) limit is depleted on the Beat4 and all Pace options.

As South Africans adjust to the 'new normal', more mental health issues may arise. Medical schemes should keep abreast of the latest trends in this regard and endeavour to assist their beneficiaries as needed. ■

**Leo Dlamini**
*Principal Officer and CEO, Bestmed Medical Scheme*

# EXPANDING INTO untapped healthcare markets

*The contentious matter of low-cost benefit options for medical schemes has been on the table for a number of years, without much demonstrable progress.*

Thoneshan Naidoo
PRINCIPAL OFFICER:
MEDSHIELD MEDICAL SCHEME

The age-old adage of 'Health is Wealth' truly came to the fore with the financial impact of COVID-19. Over the past 19 months we experienced one of the worst economic downturns in South Africa's recent history, with our GDP contracting by 7% in 2020. The impact of the healthcare crisis and the national lockdowns saw many industries, such as tourism and hospitality, brought to their economic knees, and this was further compounded by absenteeism due to ill health and the death of economically active individuals. Approximately three million South Africans have tested positive for COVID-19, and about 90 000 people have passed away. However, in a broader perspective, when you take into account the 260 000 excess deaths, that totals almost 350 000 COVID-19 deaths. Since the majority of those individuals would have been of income-earning age, this means that hundreds of thousands of families' household incomes have been affected for years to come.

But it's not all doom and gloom - there is hope. If we focus on enabling quick and efficient access to quality healthcare, we will experience less absenteeism and fewer excess deaths, which will result in South Africa becoming more productive overall. This will translate into more goods and services, which would increase the GDP and in turn elevate individual quality of life and give more households the income to live better, healthier, longer and prosperous lives.

If we can expand into untapped healthcare markets though providing easy access to quality healthcare at affordable prices we will indirectly help the GDP and create jobs. Internationally peer-reviewed literature has demonstrated a direct correlation between the health of a nation and its GDP, with some citations stating that a 1% increase in life expectancy results in an average 6% increase in total GDP.

In realising this benefit, Medshield has a two-pronged strategy to enable access to sustainable and affordable quality healthcare through innovative products and benefits. It all starts with smart primary healthcare – delivering primary healthcare in a smart manner through the combination of face-to-face consultations and the use of technological innovations to enhance access to basic care, such as general practitioners and clinics, for low-income households that cannot

afford traditional medical scheme contributions. Medical scheme coverage and benefit richness is generally correlated with income; therefore the higher the premium, the richer the benefits. Low-cost benefit options (LCBOs) will automatically bring more people into the private healthcare system and, in the process, will create opportunities for buy-ups when their financial situation improves.

However, many low-income earners not only experience affordability issues. A large portion experience barriers to access, with many having to travel far and incur transport costs when they need medical assistance. We have to make healthcare smarter. We have to provide an affordable solution through LCBOs and combine that with an easy way for low-income earners to access high-quality private medical care when needed.

The reality is that primary care medical professionals are a scarce resource, and we need to change the fundamental paradigm by asking how to make this scarce resource equitable and easily accessible to the population. Medshield's SmartCare nurse-led GP consultations, as a benefit on the proposed LCBO solution, will provide greater access since patients don't need a GP to be physically present. All that is needed is a pharmacy or clinic, a data-enabled mobile device and a nurse. The nurse will assess the patient's vital signs, temperature and the like, and conduct a video-led call with the doctor, who could then diagnose and provide treatment.

**Thoneshan Naidoo**
*Principal Officer, Medshield Medical Scheme*

The private healthcare industry is often characterised as the domain of 8.9 million medical scheme members (15% of the population). However, based on Stats SA's 2017 General Household Survey and UCT's 2014 National Income Dynamics Survey, between 16 million and 23 million South Africans access private healthcare as the first port of call on a cash basis.

Providing a more structured solution will not only provide access to healthcare but will alleviate long-term undiagnosed medical conditions, which could result in severe diseases later in life. A LCBO, offering a combination of face-to-face consultations and the use of technological innovations, is the smart solution for the existing healthcare needs of low-income earners in South Africa.

In the current economy, the need to introduce LBCOs and enable access to quality private healthcare in a sustainable and affordable manner is arguably greater than in prior years. ■

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# Let's keep it simple

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In times like these medical schemes need to go back to basics, says Josua Joubert, chief executive and principal officer of CompCare Medical Scheme. "Members are keenly aware of their need for healthcare cover, yet they are hard pressed to find lasting value when it comes to the delivery of cost-conscious benefits," he points out.

"When it comes to affordability, we recommend narrowing the focus to options that can work for individuals, families and in structured arrangements for employers with six staff members or more."

### INNOVATIVE, WELL-ROUNDED SOLUTIONS

"In times of uncertainty, the innovative medical scheme will create value from even the lowest of healthcare budgets. Take CompCare's SelfNet option, for example. Starting from R1 690 per beneficiary per month, this option provides unlimited hospital cover while day-to-day claims can be funded from savings, equating to a sizeable percentage of the contribution. The key here is that savings are fully discretionary with no sub-limits or exclusions for different types of healthcare providers," says Joubert. "And if savings are not depleted, they should be carried over to the next benefit year so members can still make use of what is rightfully theirs."

### STRAIGHT-UP RELIABILITY

Joubert points out that a truly solid hospital plan will give members complete peace of mind, such as the MedX option from CompCare, which starts at R1 741 per month. "This option ticks all the most important boxes with the necessary cover for 27 chronic conditions, a full oncology benefit and, of course, unlimited cover for in-hospital and hospital-related services, as well as cover for sports injuries."

### RICHER BENEFITS, BETTER VALUE

"Finally, for members who require something just a little more flexible, the UniSave option, starting at R2 709 per month, includes unlimited hospitalisation and a medical savings account set at the maximum permissible level of 25%. This out-of-hospital flexibility makes it one of CompCare's most popular options."

According to Joubert, this is one of the richest benefit options on the market, providing value in excess of its contribution point, meaning that members are entitled to value greater than that which they put in. This, combined with its low price point, makes UniSave a highly competitive option on the market.

"And whatever option they choose, members keeping things simple should not have to forego excellent wellness and preventative benefits," asserts Joubert. "Likewise, they should have access to a meaningful psychosocial benefit that offers round-the-clock telephone counselling from professionals, with referrals for one-on-one sessions when required."

"It is a challenging time for our country but we at CompCare are ready and waiting to provide the kind of sustainable cover members can count on, and the cover they most certainly deserve," he concludes.

*Josua Joubert, CEO and Principal Officer, CompCare Medical Scheme*

# HOW SCHEMES WORK
# Selecting the strongest value proposition

By Craig Getz
CONSULTING ACTUARY, INSIGHT

Imagine a scenario: you are the procurement officer for a large company that must purchase cell phones for 1000 employees. There are two manufacturers, namely Apricot and Celestial. Both their phones cost R10 000 per device. You have a budget of R8 000 000. That is only enough to buy cell phones for 800 employees. The 800 most senior staff will receive cell phones and the 200 most junior staff will not. This is an unfortunate outcome.

You approach Apricot and ask them for a discount. They appreciate your plight but explain that they cannot discount their prices unless you can guarantee volumes. You suggest that if Apricot discounts their devices, you will apply a R3 000 co-payment for employees who opt for Celestial's products. Apricot agrees to discount their price to R8 500 per phone.

You have the same conversation with Celestial. They agree to discount their devices to R8 000 per device should you apply a R3 000 co-payment to Apricot's. You agree to the deal with Celestial. Well done! This will allow you to source phones for all 1 000 employees within your budget.

By channelling your employees, you were able to secure deep discounts. Simplistically, this is how schemes function.

Schemes engage with the hospital groups, which then compete for volumes by proposing discounts and other value-adds. Schemes select the groups representing the strongest value proposition to

Schemes engage with the hospital groups, which then compete for volumes by proposing discounts and other value-adds. Schemes select the groups representing the strongest value proposition to the scheme and channel patients towards these groups. Network arrangements have empowered schemes to reduce contributions by up to 15%.
This increases access to care.

**Craig Getz**
*Consulting Actuary, Insight*

the scheme and channel patients towards these groups. Network arrangements have empowered schemes to reduce contributions by up to 15%. This increases access to care.

This is not to say that medical schemes cannot improve the way they select network participants.

- Some schemes lack the technical capacity needed to benchmark costs robustly. The hospital groups with the highest discounts and the lowest tariffs are not necessarily the most affordable. Affordability is a function of price and utilisation. Actuarial tools such as the Insight Diagnosis Related Grouper (DRG) are needed to reliably benchmark costs.
- Some schemes have not given sufficient attention to matters other than the cost of care when selecting network participants. Patient experience, the quality of care and economic empowerment are important considerations.
- Some schemes are not sufficiently transparent when selecting network participants.

The Council for Medical Schemes (CMS) aims to correct these and other shortcomings through regulatory changes on undesirable business practices. Efforts to foster standardisation, fairness and transparency should be welcomed. However, the CMS has asserted the need to limit the co-payments that can be applied to the voluntary use of non-network providers (to no more than the discounts offered by network providers).

> **“The proposed Undesirable Business Practice Declaration gives rise to what game theorists refer to as a ‘Prisoner’s Dilemma’.... and rational providers will realise that it is in their best interest to cease offering discounts in return for volumes.”**

AT A GLANCE

# The Undesirable Business Practice Declaration

In the Undesirable Business Practice Declaration published in Circular 24 of 2021 and gazetted in Government Gazette No 44469 on 23 April 2021, the Council for Medical Schemes announced that certain restrictions would apply to co-payments that medical schemes will be allowed to levy when a member voluntarily chooses not to make use of a network hospital, pharmacy or doctor. The consequences of this may not be in the best interest of medical scheme beneficiaries – who will likely end up having to pay more for the benefits they already enjoy when the Declaration comes into effect.

The Declaration gives rise to what game theorists and negotiation experts refer to as a 'Prisoner's Dilemma'. Healthcare providers will realise that they would be foolish to offer discounts in anticipation of higher volumes, as the eventual outcome of such discounts would leave them worse off, both individually and collectively. Rational providers will realise that it is in their best interest to cease offering discounts in return for volumes.

Contributions would become increasingly costly and access would be reduced. Members with limited financial means would be worst affected, as they would have to forego medical scheme cover if they could no longer afford it.

An overly simplistic interpretation of this limitation would be that lower co-payments are beneficial to consumers. In our view, this limitation will most likely prevent schemes from securing meaningful discounts from network participants. This would make contributions more expensive and reduce the number of people who can afford to belong to medical schemes.

Consider the cell phone example. You secured discounts because the manufacturer knew that the cost of exclusion exceeds the cost of discounts. Now assume that regulations had prevented companies from applying a co-payment higher than the discount offered by the preferred manufacturer. The advantages of being a preferred manufacturer would be nullified and discounts would soon become a thing of the past.

The non-preferred manufacturer could maintain its market share by writing off co-payments. Given that co-payments could no longer exceed the discounts provided by the preferred manufacturer, this would be economically viable. The preferred manufacturer would not experience an increase in market share and would be no better off. There would be no incentive for manufacturers to offer discounts. The result would be higher prices and less access.

The proposed Undesirable Business Practice Declaration gives rise to what game theorists refer to as a 'Prisoner's Dilemma'. Providers will realise that they would be foolish to offer discounts in anticipation of higher volumes, as the eventual outcome of such discounts would leave them worse off both individually and collectively. Rational providers will realise that it is in their best interest to cease offering discounts in return for volumes.

There are other compelling and non-financial reasons why schemes want to levy co-payments that exceed the discounts offered by network providers. Irrespective of the willingness of non-network providers to match the discounts offered by network providers, the scheme may wish to channel its members to network providers. This is because network providers may be associated with superior outcomes, patient experience, empowerment credentials or cost efficiencies.

Restrictions on co-payments are the unintentional enemy of improved healthcare outcomes, patient experience, empowerment and cost-efficiency. Healthcare providers will also be adversely impacted by these restrictions as scheme membership would decline due to reduced affordability.

Such unintended consequences of the announced Undesirable Business Practice Declaration are concerning. We caution that extreme care should be applied when considering any such amendments. ■

B·H·F

BOARD OF HEALTHCARE FUNDERS

# Our Value Proposition

## 1. REPRESENT MEMBER INTERESTS

- Lobby and advocate policy position on behalf of our members
- Assist members with regulatory compliance
- Provide legal advice to membership on industry issues
- Assist in containing healthcare costs
- Protect the image of the industry
- Identify and monitor trends impacting our members

## 2. CREATE PLATFORMS FOR MEMBER ENGAGEMENT

- Promote unity and collaboration by creating platforms that enable our members to engage with the BHF and participate in industry issues
- Create networking opportunities
- Engage and develop relationships with key stakeholders

## 3. DEVELOP INDUSTRY STANDARDS

- Promote best practice in the healthcare funding industry
- Promote healthcare quality
- Identify and recognise key role players in the industry

## 4. FACILITATE EDUCATION AND TRAINING

- Provide guidance
- Provide stewardship and facilitate thought leadership exchange on industry issues
- Enhance skills and knowledge within our membership
- Progress tracking reports on industry issues
- Promote stakeholder, consumer awareness and medical scheme member education

## 5. TRANSFORMATION THROUGH DEVELOPMENT

- Identify opportunities to drive transformation in the industry
- Graduate programme development

## PROVIDE AND IDENTIFY OPPORTUNITIES

- Profile our members and our industry

# Reimagining the future of healthcare

Momentum Metropolitan is a South African-based company listed on the Johannesburg Stock Exchange and the Namibian Stock Exchange, and the first major insurance group to reach Level 1 Broad-Based Black Economic Empowerment (B-BBEE) status under the revised Financial Sector Code (FSC).

Momentum Health Solutions (MHS) and Metropolitan Health Corporate (MHC) are subsidiaries within the Momentum Metropolitan group of companies, strategically placed to enable and deliver sustainable, integrated outcomes-based healthcare solutions. Our experience in designing and delivering sustainable healthcare solutions extends to more than 2.8 million lives in South Africa, and further influencing more than 17 million lives globally within our portfolio of schemes within the rest of Africa and in collaboration with our joint venture partner in India, where we co-deliver health insurance solutions. This is testimony to our experience and capabilities to provide in-depth insights and comprehensive solutions. This is testimony to our capabilities and years of experience in providing integrated solutions that deliver results for our clients.

With the purpose of providing more health to more people, the health solutions business represents a culmination of solutions and capabilities that supports and empowers Health Citizens – consumers with specific needs, varying business segments and unique medical scheme profiles – on their journey towards achieving appropriate and sustainable healthcare. An organisation that understands the healthcare landscape on local and global scales, we aim to partner with medical schemes and employers in facing not only healthcare industry challenges, but also the socio-economic challenges associated with healthcare provision in South Africa.

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## Our healthcare offering

Our healthcare business has access to a wide range of administration, health risk management and wellness capabilities that allow us to deliver on our purpose. In addition, our value proposition is coupled with complementary health products that incentivise and reward healthy behaviour, along with workplace health and wellness solutions geared towards supporting employers and employees enjoy better outcomes.

Our solutions connect the needs of the employer with the aspirations of the medical scheme. This is done by integrating occupational health and workplace wellness services with our medical scheme disease management capability, and by offering insights into risk and engagement levers that protect the bottom line. Additionally, our niche occupational hygiene unit provides employers with tangible surveillance and health and safety compliance solutions.

### Dr Hannes Viljoen

**CEO: Momentum Metropolitan Health - Momentum Health Solutions**

As head of the health business for Momentum Metropolitan Holdings, Hannes leads the health team with a great depth of experience and skills, gained from working in private healthcare funding for the past 23 years. His qualifications include BChD, MChD and DHA degrees, along with an MBL from Unisa. Having spent five years in a dental practice and three years in a private hospital, Hannes joined Ingwe Health in 1998, started Pulz – which grew into Momentum Health – and has worked in the Momentum Metropolitan health business for the past 17 years.

His innovative thinking had led to various health cover innovations in South Africa, from assisting to establish the first banking solution for health (HealthSaver), to implementing the first incentivised lifestyle programme (HealthReturns). And there were significant industry developments along the way, including the designated service provider model now adopted in industry legislation and the Momentum Metropolitan merger, forming part of the team who shaped the new entity post-merger, orchestrating a turnaround that saw it becoming the market leader it is today.

### Dr Ali Hamdulay

**CEO: Metropolitan Health**

In his role as CEO, Ali has focused on providing healthcare solutions in the public sector segments. Having served the healthcare industry for over 20 years in many senior positions, Ali has developed vast expertise in the healthcare field, including medical scheme administration, wellness and managed care. Ali has a comprehensive understanding of the healthcare ecosystems, identifying critical role players, markets dynamics, inter-dependencies and functioning. He has forged strong relationships across the sector funder community, regulatory bodies and government leaders, and has developed a prominent reputation as an industry thought leader. Ali has also had the pleasure of serving as Chairperson of the Board of Healthcare Funders (BHF).

**Our mission is to offer more healthcare to more South Africans for less** and we invite you to partner with us on this journey as we reimagine the future of healthcare.

# PHARMACIST-INITIATED THERAPY and the supplementation of training: a 27-year review

*In this article, we review pharmacist-initiated therapy (PIT) as part of the scope of practice of a pharmacist in South Africa, as legislated throughout the period since 1994. This reference period was purposely selected as it entails the most active period for the definitions of scopes of practice and the required supplementary training for pharmacists.*

By Vincent Mpoye Tlala
REGISTRAR & CEO:
SOUTH AFRICAN
PHARMACY COUNCIL

In terms of the Medicines and Related Substances Act, 101 of 1965, pharmacists are empowered to initiate the therapy of patients utilising medicines and other scheduled substances up to Schedule 2 as part of their standard scope of practice, but are able to do so using medicines above Schedule 2 only with authorisation from the Director-General of the National Department of Health, which usually takes the form of a Section 22A(15) permit. In this article, I intend to review pharmacist-initiated therapy (PIT) as part of the scope of practice of a pharmacist in South Africa, as legislated throughout the

**“As the country moves towards universal health coverage, we expect to see PIT contributing tremendously towards improving access to primary healthcare and ensuring that ailments requiring clinician care are identified earlier...”**

period since 1994. I pick this reference period as it entails the most active period for the definitions of scopes of practice and the required supplementary training for pharmacists.

## DEFINING PIT THROUGH LEGISLATION OVER THE YEARS

While PIT had preceded democracy in South Africa, as the administration of former President Nelson Mandela took office in 1994, so did a new need to review structures of various sectors and the legislation governing them.

The first Minister of Health in the democratic dispensation, Dr Nkosazana Dlamini-Zuma, established various requirements for certain elements of PIT and, in response to the disease burden and lack of access to healthcare services by the majority of South Africans, introduced the supplementary training requirements for both Primary Care Drug Therapy (PCDT) and Family Planning through the supplementary training regulations gazetted in August 1995. This was to enable pharmacists who complete such training to apply to the Director-General for Section 22A(15) permits granting them permission to provide care and therapy for defined healthcare needs. This is still in place today.

Further confirmation of PIT as part of the scope of a pharmacist took place during the tenure of the second Minister of Health, the late Dr Manto Tshabalala-Msimang. She gazetted the Regulations relating to the practice of pharmacy in November 2000, which provided a clearer definition of the services and therapy a pharmacist may provide, also ensuring that the desire of healthcare workers (pharmacists, in this case) for exclusivity never trumps national health goals. These regulations further confirmed PIT as an act within the scope of practice of a pharmacist.

Importantly, however, within these regulations provision was made to ensure that the dispensing of medicines was no longer an exclusive terrain, as provided for in Section 29 of the amended Pharmacy Act. This was also done for other practitioners, including those regulated by other statutory health councils. In October 2009, then Minister of Health, Dr Aaron Motsoaledi, gazetted the Regulations defining the scope of the profession of medicine, which also emphasised the need for collaborative work among healthcare workers in pursuit of national healthcare goals. At the time, it was reiterated that the provisions relating to the medicine scope of practice ‘shall not be construed as prohibiting the performance of the acts specified therein by any person registered under any legislation regulating health care providers from performing such acts in accordance with the provisions of such legislation...’ (Regulation 3(a)).

## THE HISTORIC BENEFIT OF PIT

PIT programmes including PCDT, family planning and the expanded programme on immunisation (vaccination) have been helping the nation reach its healthcare objectives for several decades through both screening for and treatment of various defined ailments, provision of family planning services and vaccinations against pathogens causing diseases such as influenza, tuberculosis, diphtheria, measles and polio. These services have been utilised by both private and state patients in some provinces.

**Vincent Mpoye Tlala**

*Registrar & CEO, South African Pharmacy Council*

During the COVID-19 pandemic we are seeing just what is possible when PIT is allowed the space to contribute to ensuring accessibility of healthcare services in collaboration with other healthcare workers. Pharmacy facilities constitute the largest cohort of vaccination sites outside of the state, with more than 90% of approved private COVID-19 vaccination sites being pharmacies. For this we have legislators of the 1965 Medicines Act, and the various Ministers of Health since 1994, including the current Minister of Health, Dr Joe Phaahla, to thank.

## THE ENVISAGED FUTURE OF PIT AS A CONTRIBUTOR TO THE ACHIEVEMENT OF NATIONAL HEALTHCARE NEEDS

It is hard to imagine a future without PIT, an existing part of the pharmacist scope of practice with a legislated history of more than five decades. South Africa, as a country with only 503 healthcare workers and just 33 medical practitioners per 100 000 public sector population will greatly benefit from sustaining the existence of PIT. First-world countries with higher-than-recommended healthcare worker to population ratios have implemented PIT in managing many diseases, including HIV/AIDS, with tremendous results in prevention, testing and treating.

As the country moves towards universal health coverage, we expect to see PIT contributing tremendously towards improving access to primary healthcare and ensuring that ailments requiring clinician care are identified earlier and that affected patients are referred appropriately within the healthcare team.

The bottom line? Improved life expectancy and quality of life for more people. ■

# SPECIAL FEATURE

## The Healthcare Industry Unites Against COVID-19

In this special feature, we pay tribute to the work of healthcare companies across Africa during uncertain and trying times, recognising and celebrating the innovations, actions and commitments of schemes in the ongoing fight against COVID-19.

AfroCentric GROUP
Healthier Together

# COMMITTED TO HELPING employers vaccinate their workers

*We joined this noble effort because we believed it was our duty as a responsible corporate citizen to help vaccinate as many South Africans as possible, starting with the four million lives under our administration*

South Africa, along with the rest of the world is in the midst of the biggest health crisis since perhaps the Spanish flu pandemic of 1918.

The COVID-19 pandemic that has gripped the world for nearly two years has changed the way we live and interact with each other, and tragically has also cost us millions of lives and livelihoods. Vaccinations remain the only real weapon against the coronavirus and it is up to all of us to encourage all eligible residents of South Africa to go out and get vaccinated.

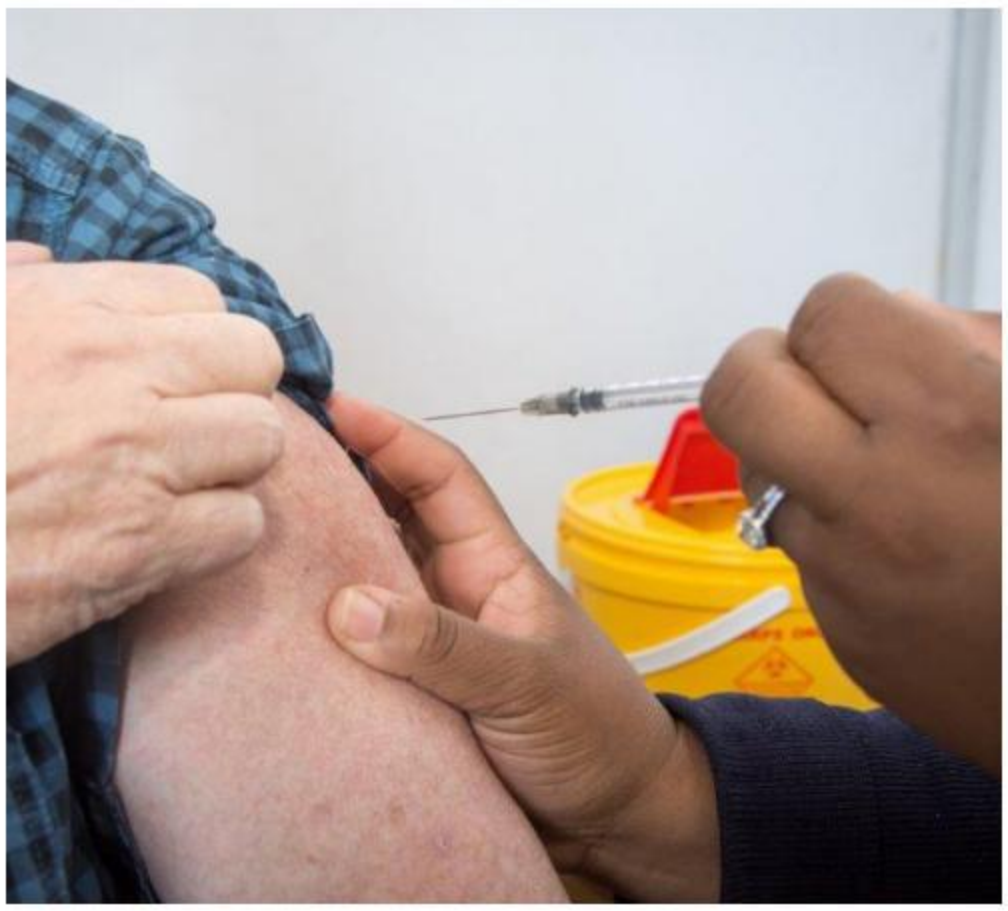
Since the government's vaccination rollout began on 17 May 2021, the AfroCentric Group has been at the forefront of the drive. We joined this noble effort because as a diversified healthcare company with the requisite resources, we believed it was our duty as a responsible corporate citizen to help vaccinate as many South Africans as possible, starting with the four million lives under our administration


through our medical schemes administrator, Medscheme.

We launched our response initially with the intention of providing access to vaccinations for our staff and member schemes. To that end, six Medscheme sites (inclusive of Sanlam sites) were rolled out, namely Medscheme Florida, Medscheme Louwlardia (Pharmacy Direct Offices), Medscheme Durban, Medscheme Cape Town, Sanlam Houghton and Sanlam Bellville.

To date, we have administered in excess of 200 000 vaccinations, including those administered to nearly 90 000 members of the police force. While we are proud of this achievement, we recognise that more can be done. Given that our data suggest that vaccine hesitancy levels are at around 40%, this means it is up to us to work harder to get the remainder of the scheme population vaccinated. We believe that businesses in the private sector can support this by encouraging their employees to take the jab.

Fortunately, employers are taking this role to heart – AfroCentric has seen growing interest



# GUIDE FOR EMPLOYERS

## *HOW TO SET UP VACCINATION SITES AT YOUR PREMISES*

1. A site has to be accredited and registered on the Master Facility List (MFL) which can be accessed online at https://mfl.csir.co.za
2. A business is also able to collaborate with a registered primary healthcare vaccination site. In this way, the employer can serve as a secondary site and does not need to be accredited, which will be the responsibility of the primary site. The primary site will receive the vaccine doses and the secondary workplace will collect from this site.
3. Any person at the employer's site who is undertaking vaccinations will need to complete vaccinator training. Alternatively, the employer can outsource this task to a professional occupational wellness service provider. All mobile services will be linked to a primary registered site.
4. All applicable regulations including masks, sanitisers, social distancing and waste disposal must always be handled with the utmost care. The site needs to look like and should be on a par with a hospital or clinic. There is no room to increase the spread of COVID-19 while we are vaccinating against it.
5. An enhanced screening process is performed at all sites to protect the companies' employees and our staff and to prevent the spread of infection in the corporate premises.
6. Lastly, employers should always look to the National Department of Health for guidance, as the government manages the country's vaccination drive. The regulations are there for a reason and there are plenty of avenues for support and information.

# AT A GLANCE
## *OUR ACHIEVEMENTS*

- AfroCentric Group is proud to have made a significant contribution to the government vaccination drive, having established six vaccination sites across the country.
- AfroCentric Corporate Solutions has administered in excess of 200 000 vaccines to residents of South Africa.
- The Group also partnered with the government to vaccinate nearly 90 000 members of the police force.
- AfroCentric Group subsidiary Pharmacy Direct's Central Chronic Medicine Dispensing and Distribution (CCMDD) Centre is a private-public partnership with the National Department of Health that delivers chronic medication to state patients countrywide. To date, Pharmacy Direct has registered more than 2.5 million CCMDD patients, of whom more than 1.2 million are active patients dispensed to every month. Throughout the lockdown period, the centre ensured that patients were able to receive their chronic medication without leaving their homes and compromising their health.

AfroCentric GROUP
*Healthier Together*

on the part of corporates and private organisations in hosting onsite vaccination campaigns for their employees and we have responded to this need. Through our corporate wellness cluster, AfroCentric Corporate Solutions, we have been providing mobile vaccination services to corporates, universities and schools.

Our decision to launch this mobile solution could not have come at a better time. Employers, keen to bring employees back to the workplace, have been seeking a vaccination solution that enables hassle-free access. The mobile solution enables them to encourage their workers and their families to come to the sites to get vaccinated.

As AfroCentric, we have partnered with employers by providing qualified nurses to administer vaccines sourced through hospitals or pharmacies. We remain committed to these partnerships as we believe that it is only through vaccinations that we will be able to return to the levels of economic activity needed to recover from the impact of COVID-19. South Africans are desperate to return to some level of normalcy and we are proud to be able to help make that possible.

*For more information on how AfroCentric can support employer-led vaccinations at their premises, please contact us at: info@wellnessodyssey.co.za.*

Universal
Healthcare

# TRANSFORMING HEALTHCARE CONSULTATIONS

## in the time of COVID and beyond with uConsult™

We take a look at how, in a time of necessity, Universal Healthcare and uConsult successfully connected patients with healthcare providers using safe, scalable microservices technology

Thomas Edison said: "There's a way to do it better – find it." In a time of unprecedented change the pressure to adapt has resulted in some remarkable healthcare developments, to do things not only differently but, in some cases, better.

"As a healthcare administrator, we saw a broad spectrum of challenges that arose quickly once the pandemic had hit our shores, which brought about the need for long-term solutions," says Dr Johan Pretorius, CEO of Universal Healthcare.

"Perhaps the most notable of challenges at ground level was the sudden change in the dynamic between provider and patient. Where once a face-to-face interaction was so essential, caution on the part of both parties now meant that consultations in rooms would only take place if absolutely necessary. This had a far-reaching financial impact for doctors, who could no longer practise as they had before, while the break in continuity of care often resulted in patients neglecting their general health."

### INNOVATION FOR ACCESSIBILITY

Dr Pretorius notes that while telemedicine is not a new field, the legislation passed by the HPCSA along with the sudden need for a streamlined virtual consultation offering, provided a timely opportunity to develop uConsult™.

"With the advent of COVID-19 the need for a sustainable alternative consultation model became clear. Following discussions with key stakeholders at various schemes we moved quickly, engaging our international innovation team based in Silicon

> **"The uConsult platform was built to be totally agnostic – not aligning itself to any medical scheme, nor indeed requiring patients to have medical scheme membership."**

## HIGHLIGHTS
### *WHAT WE ACHIEVED IN A TIME OF NECESSITY*

- Reaching out to key stakeholders in medical schemes and the healthcare community resulted in some important conversations and insights around just what was needed to solve the problem of face-to-face patient consultations. This type of collaborative approach, in times of such difficulty, proved highly beneficial in laying strong foundations for new ideas.
- Taking quick action and identifying the right development team for the job went a long way towards ensuring that this new virtual consultation platform would be built at the very forefront of technological innovation. In this process we saw clearly that having an idea is one thing, getting it done is another but getting it done right requires a carefully defined vision and a high level of input and resourcefulness.
- Engaging the users – healthcare providers – in finding out exactly what their needs were, not only provided valuable insight for product development but began to create a deeper sense of where our healthcare community is going in the future and just what potential digital solutions have in respect of assisting provider-patient interactions to evolve.
- uConsult now has a total of eight medical schemes, both closed and open, already supporting and endorsing the platform as well as a fast-growing user base of healthcare providers and patients nationwide. Building for accessibility for the healthcare industry as a whole, here in South Africa and internationally, is an essential step in digital transformation.

Universal Healthcare

Valley, California, who immediately began development of a responsive web-based platform," he says.

While many other platforms were in development at the same time, Dr Pretorius points out that the uConsult difference lay in the fact that the team understood the importance of maintaining a strong focus on accessible care, throughout the healthcare industry, from the outset. For this reason the platform was built to be totally agnostic – not aligning itself to any medical scheme, nor indeed requiring patients to have medical scheme membership.

Furthermore, the platform does not require software installations. Rather, it is able to launch from a web browser, enabling access from any smart device and increasing ease of use for both provider and patient.

### REACHING OUT TO HEALTHCARE PROVIDERS

"There was a pressing need to get uConsult as close to perfect as possible within the first iteration. We therefore reached out to healthcare providers from multiple disciplines in order to gain user perspective and to help us simulate existing processes followed in a healthcare practice. These included patient bookings, checking in, issuing pathology and radiology requests and scripts, managing billing and making medical notes.

"We wanted the platform to provide an intuitive and streamlined digital version of these largely analogue processes, not only to enable doctors to see patients virtually but to assist with the digital transformation of their practices well beyond that.

"It was also important that we be able to ensure that patient confidentiality remains intact, and that the protection of personal information would never be jeopardised. uConsult is therefore fully POPIA compliant, thus assisting doctors in the legally correct management of patient databases."


Dr Pretorius says that after initial testing and a successful pilot phase, the product went live in South Africa in July 2021.

With the approval and support of independent healthcare bodies, private practices and eight medical schemes and counting, uConsult is quickly becoming the definitive virtual consultation platform for the entire South African healthcare industry.

## SO, WHAT EXACTLY DOES THE PLATFORM OFFER?

Unlike other virtual consultation platforms, uConsult connects patients with healthcare providers using safe, scalable microservices technology. The platform's functionalities include schedule management, video chat and screen sharing, the transfer of encrypted medical documents, upfront or immediate patient billing and the digital storage of medical notes.

Users are able to search for general practitioners on uConsult by name or geolocation and virtual consultations can take place no matter where the patient is based, locally or internationally. The patient and healthcare provider are, in addition, able to connect with other practitioners without having to switch between systems – a revolutionary development.

"It is just the beginning of a new era for the management of healthcare interactions. At Universal, this comes down to innovating and creating solutions that ultimately hinge on so much more than convenience – it is about making inroads into accessibility, sustainability and connectivity for all, within and beyond our borders," concludes Dr Pretorius.

*For more information visit www.u-consult.co.za or call uConsult director Anton Paich on 078-095-9580*

uConsult™

TITANIUM AWARDS
Recognising Excellence in Healthcare

# 2020 Award Recipients

The Board of Healthcare Funders hosted the sixth annual Titanium Awards last year. This event was held on Wednesday 15th November 2020 on a virtual platform and sponsored by Insight Actuaries and consultants.

The 6th annual Titanium Awards once again cast a spotlight upon organisations and individuals dedicated to providing programmes and initiatives that are creating access to healthcare services. The 2020 Awards included the following categories:

## 1. EXCELLENCE IN CREATING ACCESS TO HEALTHCARE

The award seeks to honour organisations driving programmes, initiatives and campaigns that create access to healthcare for communities. The award is open to individuals and all organisations in the healthcare sector, including medical schemes, administrators, pharmaceutical companies, public and private facilities, managed care companies, SMMEs, healthcare professionals, non-profit and government agencies; including CSI programmes.

## 2. SERVICE TO MEMBERSHIP: OPEN, CLOSED & SELF-ADMINISTERED MEDICAL SCHEMES, MANAGED CARE ORGANISATIONS AND ADMINISTRATORS

This award recognises and rewards medical schemes (open, restricted and self-administered), administrators and managed care organisations providing the best service to their members. It celebrates industry excellence and unprecedented contributions to members by providing value for money.

## 3. THE BEST PAPER AWARD

This award recognises healthcare-centric papers providing information that is relevant and appropriate to the intended readers. After reading the paper, the reader should have learnt something and be able to apply new knowledge. The paper should have a clear and logical presentation, needs to be readable by the whole interdisciplinary audience and not just by specialists in some sub-field. Any interested reader should be able to learn something from the paper.

*Congratulations to the 2020 Titanium Award winners!*

## *2020 Titanium Award for Excellence in Creating Access to Healthcare*

# INDIVIDUAL: **Dr. Margaret Venter**

Dr Venter is the current Secretary and co-founder of The Association of Palliative Care Practitioners of South Africa. In the time of COVID-19, her long-standing belief in palliative care access, her commitment to patients, her innate compassion and her tireless energy have come into sharp relief. It is her belief that everyone should have access to clear and honest communication about their illness, access to pain management, choices about how they die and, where possible, no one should have to die alone. Dr Venter is a palliative care trained oncologist. She runs her own palliative care practice in Stellenbosch, Enfold, which aims to facilitate, coordinate and support a multidisciplinary palliative care team for each patient, bringing general practitioners, palliative care nurses and other providers into the fold.

## *2020 Titanium Award for Excellence in Creating Access to Healthcare*

# ORGANISATION: **BestMed**

Bestmed is a self-administered medical scheme operated by members, for members and provides the best value and highest quality, innovative, preventative and curative products that are readily accessible to all beneficiaries from a network of competent healthcare professionals. Bestmed has one of the most extensive service provider networks of all the medical schemes, with over 15 800 healthcare providers and ancillaries.

## *2020 Titanium Award for Service to Membership*

# **Medscheme**

Medscheme Holdings is accredited as a managed care organisation with the Council for Medical Schemes. The main purpose of all its interventions is to decrease the variability in the quality and cost of healthcare services. Medscheme has implemented several beneficiary management programmes which are both science-based and standardised.

## *2020 Titanium Award for the Best Paper*

# **Impact of Underwriting on a South African Medical Scheme**

Barry Childs: Joint CEO,
Insight Actuaries and Consultants

Mudanalo Shavhani: Actuarial Consultant,
Insight Actuaries and Consultants

Rachael van Zyl: Actuarial Consultant,
Insight Actuaries and Consultants

REGIONAL UPDATE

BOTSWANA

# Botswana emerges from devastating COVID-19 third wave

*Dr Khumoetsile Mapitse, Principal Officer: Pula Medical Aid Fund*

Botswana was not spared when the third wave of COVID-19 ravaged southern Africa and experienced some of the highest rates of infection, resulting in an unprecedented number of hospitalisations and COVID-19-related deaths.

During this period healthcare infrastructure was overwhelmed by the demand for services. Both the public and private healthcare sectors were not coping, with hospital beds in short supply and oxygen being the main limiting factor. Various stakeholders came together to mitigate the effects of COVID-19; the government of Botswana funded the capacitation of various public health facilities with extra oxygen reservoirs and medical aid schemes collaborated with other industry players to assist the government with the procurement and distribution of vaccines.

The schemes responded by offering free testing for their members and some went as far as providing unlimited free COVID-19 cover for all their members, regardless of benefit option, ensuring that they received the best care possible without having to worry about paying a single thebe. When health facilities became overwhelmed to the point where patients were sent home, schemes responded by offering home-based care services, virtual consultations, doctor home visits, access to oximeters and oxygen concentrators and supplements as a way of going the extra mile for their members. The free unlimited COVID-19 cover was intended to get members to access healthcare early before they could develop complications.

The situation is currently under control with the prevalence having declined significantly and mortality also at its lowest since the onset of winter 2021. Health facilities have been strengthened and should be in a better position should another wave arise in future. The vaccination rollout started off very slowly, but gained momentum in the third quarter of 2021, with around 14% of the population now fully vaccinated as of October 2021.

Medical schemes have joined in the effort to assist in the vaccination of their members by covering the cost thereof. One of these, Pula Medical Aid Fund, has opened a vaccination centre, the largest in the country, to the general public at no cost to vaccine recipients. Schemes are assisting government's efforts to have 60% of the eligible population vaccinated by the end of 2021. ■

ESWATINI

# Impact – student visa impasse

The Kingdom of eSwatini has a high number of young and old people who seek better and affordable education in the South Africa and other countries in the SADC, Africa and overseas. These include Swazimed-dependent members and non-Swazimed student members.

Over the years, Swazimed has improved its working relationship with South African service providers, and the Swazimed card is widely accepted by South African hospitals, specialists, pharmacies, GPs and other service providers. Confirmations of benefits are done online 24/7 and claims submissions are effected through EDI which, in turn, enables quick payments through electronic funds transfer. Payment runs are also done on a weekly basis. All these make it easy for providers to accept Swazimed card-carrying members all over South Africa.

With the implementation of the non-acceptance of students registered on foreign medical aid schemes by the South African Embassy, a number of Swazimed membership card-carrying students struggled to obtain student visas to study in South Africa, while still being accepted elsewhere in the SADC, Africa and overseas. The non-acceptance continued even after it was proved that the Swazimed membership card is widely accepted by South African service providers.

The South African Council for Medical Schemes (CMS) was engaged for recognition in order to make it easy for eSwatini medical aid-registered students to obtain a student visa.

The council then undertook discussions with the various regulators, which act on behalf of all medical aid schemes. We are banking on the outcome of the discussions between the CMS and the country's regulators. We hope that non-South African schemes that can prove their acceptance by South African service providers will be granted an exemption that will result in students obtaining visas.

The over 1500 Emaswati students currently registered with Swazimed are referred to South African health insurance companies and Swazimed pays for their contributions, which tend to be more expensive to the fund because the registration of the student as a dependant on Swazimed is far below what Swazimed pays on behalf of the student belonging to a South African health insurance scheme.

This, in itself, has a huge impact on the financials for the scheme since contributions per student amount to +E5000.00 on an annual basis, which totals over E7 500 000.00 annually.

Once our dependents have purchased South African medical insurance or medical aid, they still continue to use SwaziMed.

*Peter Simelane, Principal Officer, Swazimed*

REGIONAL UPDATE

LESOTHO

# A blueprint for Lesotho's healthcare system

*Manthati Phomane, Principal Officer, Mamoth Health*

The global progress towards curbing the spread of COVID-19 and its highly contagious variants is an ongoing and dynamic challenge. In the case of landlocked Lesotho, the country has been forced to introspect and look at its extremely strained and highly compromised healthcare infrastructure. A corresponding healthcare services agenda, which focuses on a sustainable healthcare system in partnership with the private sector on public health, is now emerging. This private-public partnership will succeed only through dialogue and development of solid frameworks.

From the transportation of vaccines to the sponsoring of PPE, Lesotho has experienced encouraging examples of successful public-private partnerships during this trying time.

In order to support and foster the progress and development of the public health sector, there is a need for public policy and economic reforms for an enabling environment that catalyses innovation for contextualised healthcare responses. These include innovative laws for research and development of locally manufactured medicines from natural resources, such as medical cannabis, the establishment of active national health regulatory authorities, and the improvement of the bills and laws relating to the healthcare system. Collectively, when well harnessed, these could result in Lesotho becoming a medical tourism destination for the SADC region and beyond.

There is a need for an agile regulatory framework that safeguards a world-class standard for ethical biomedical innovations, skills transfer, and to guarantee that any value created is beneficial to Lesotho's healthcare industry. This will mitigate abuses and meaningfully contribute to the fiscus.

An overall improved healthcare framework will ensure that public healthcare is adequately furnished with primary healthcare essentials that enable private healthcare support throughout the country.

Undoubtedly, the survival, dignity and life expectancy of the Basotho nation will improve when the availability, affordability and accessibility of healthcare services become a reality for all citizens, everywhere in Lesotho.

MALAWI

# Unity in diversity: Healthcare Funders Association of Malawi

Malawi is a country with low rates of medical scheme membership. According to the Malawi Demographic and Health Survey (MDHS, 2020), membership of all medical schemes accounts for less than 2% of the total population. There are both open and closed schemes operating on the Malawian market, with most closed schemes being those of government agencies and parastatals.

There are a lot of challenges in the industry, including but not limited to lack of industry legislation; inconsistent and high tariffs; clinical practice-related challenges; emerging diseases challenges such as COVID-19; and fraud, waste and abuse. In view of these challenges, in June 2018, the medical schemes agreed to form an association, the Healthcare Funders Association of Malawi (HFM).

The membership of HFM comprises all major players in the medical schemes industry to help deal with the various challenges outlined. The lack of legislation within the industry has led to several problems, such as an unlevelled playing field consequent on the unnecessarily high controlling power of healthcare providers.

It is hoped that once HFM is fully functional, it will help push for legislation of the industry that will lead to market sanity for the benefit of all stakeholders, most importantly the members. In addition, healthcare providers took advantage of the market fragmentation in medical schemes to apply inconsiderate and expensive tariffs. However, the coming of HFM will control this tendency by implementing collective bargaining in respect of tariffs.

Because of lack of legislation in the industry, there is a clinical practice challenge in that healthcare is normally overserviced or overprescribed. This is closely associated with fraud, waste and abuse, which are estimated to account for 15-20% of total claims received by schemes. Therefore, HFM will help develop the necessary standards to curb these challenges and link with relevant bodies such as the Medical and Nurses' Councils of Malawi, which regulate healthcare practice in the country.

Finally, the emergence of COVID-19 further exposed the fragmentation of the schemes industry when institutions failed to come up with solutions to help their members. At one point, schemes used the pandemic as a marketing tool instead of helping to fight it. HFM will therefore bring all parties together to develop standards to address such shocks as they emerge.

In conclusion, medicine is dynamic and it is therefore imperative to unite in diversity through HFM to deal with both existing and emerging challenges such as COVID-19. ■

*Fortune Kanyemba, Operations Manager, Medhealth*

NAMIBIA

# Partnerships are key to successfully address challenges of a pandemic

One of the major lessons we have learned in Namibia during the past year is that a pandemic is best addressed when all stakeholders work in partnership. This has not only been proven in Namibia, but applies to the SADC region and Africa too.

The experience is expected to provide policymakers, funders, healthcare professionals and the private sector with new insights and guidance for ensuring successful collaborations in the future. In Namibia this will not be restricted to developing a better pandemic preparedness and response strategy, but will also assist us in facing the challenge of addressing the long-overdue healthcare reform process. The process of further exploring collaboration in Namibia's healthcare market will be frustratingly slow and ineffective if all stakeholders don't acknowledge and commit to 'what is best for the country' and not that of individual constituencies. Our success during the recent coronavirus pandemic has demonstrated the intricate interconnectedness and interdependence of stakeholders in Namibia.

Everyone was impacted by time constraints and limitations on resources, yet what commendable efforts we witnessed. Of course one can always do better, but we also have to appreciate that we can only do what our means allow.

The broader collaboration and sharing between the public and private health sectors, as well as the participation of private business sectors, are commendable evidence of the Namibian spirit of 'Harambee' – which means 'to pull together in the same direction'.

To mention a few areas of integrated collaboration during the pandemic: setting up an integrated network of testing laboratories, acquisition and distribution of vaccines, sharing hospitals beds and high-quality ICU care and collaboration in the hospital sector. In both public and private health sectors the willingness of private funders and insurers to carry hospital costs, testing fees, pre- and post-COVID medication and treatment and vaccine costs was welcomed.

The Healthcare Industry Forum of Namibia also proved to be a willing partner and demonstrated great leadership in contributing to this success.

*Callie Schäfer, BHF Representative: Namibian Member Funds*

Successful collaboration requires trust and commitment, and distrust among stakeholders has probably been partly removed during the COVID pandemic; at least the scene has been set for open engagement going forward.

Legislation can only provide a supporting framework and governance models, and cannot drive transformation and reform. To ensure success we need to implement a process that allows flexibility and Namibian stakeholders to compromise.

The saying goes: 'No man is an island', and it has become clear that members of the healthcare community in the SADC region need to stand together and support one another. We can focus on the development of benchmarking and global fees, adoption of a standard coding structure and the setting of a regional medicine pricing and benchmarking pricing model. In the absence of standard coding principles and common methodologies when recording clinical events, it would be difficult to meaningfully compare the cost of healthcare delivery across the region. More specifically, the BHF has to work with the SADC Health Desk and individual country stakeholders to add value to the process. ■

REGIONAL UPDATE

ZIMBABWE

# The benefits of medical schemes running their own primary care clinics

*Ms Thembi Mloyi Ncube, Principal Officer, BonVie Medical Aid*

The concept of integrated healthcare has grown over the last 20 years and usually begins with the scheme setting up its own primary healthcare facilities. As BonVie, we have studied these models and we understand the value added to a medical scheme member when we run our own facilities. Adopting this integrated healthcare approach comes with several benefits for medical aid schemes that ensure continued growth and expansion.

One of the significant benefits of schemes running their own primary care clinics is that having a healthcare facility allows schemes to provide continuous and comprehensive care to their members.

This means that as medical aid schemes, we can provide medical assistance to our members without relying on external facilities, which may be hard for them to access and have cost and quality control issues. For instance, a scheme-owned facility provides immediate medical attention to members and guarantees convenient access to high-quality care at a reasonable price. This also helps a scheme retain its membership.

The other advantage of medical schemes running their own primary care clinics is that it allows for data collection from the members using these facilities. These data can help schemes implement managed care and run wellness activities aligned to the data.

Fund retention is another benefit of schemes running their own primary care clinics. By having their own facilities, medical schemes can reduce fraud, waste, and abuse, which have become rampant in our country. We are also able to retain funds through claims management. It gives the medical scheme insights into what is involved in the healthcare provision and delivery of these services; these insights can be used to assess claims from such centres.

In addition to the above-mentioned benefits, the running of primary care clinics by medical aid schemes has also brought relief to the country's ailing healthcare system. ■

# BHF DIALOGUE

CONNECT • ENGAGE • COLLABORATE

2021 SERIES

By Mary Manamela
KEY ACCOUNTS MANAGER, BHF

The 2021 BHF Dialogue online series kicked off in September with a dialogue on the National Health Insurance (NHI), followed by a discussion on Fraud Waste and Abuse in October and closing with a Technology in Healthcare dialogue in November. The three-part series of round table discussions, which seek to connect health-care professionals and enable engagement and collaboration on issues impacting the healthcare ecosystem, was held on a virtual platform.

## THE PROGRAMME

We hosted an array of industry experts who shared their knowledge and expertise across a broad range of topics, covering issues and challenges facing the industry in 2021.

### SERIES 1: The NHI Dialogue

*Theme: The NHI Bill, fit for purpose? The need to put the health citizen first*

**Key highlights from the session:**

- The question of whether the NHI Bill is fit for purpose is centred on the fact that people are uncomfortable about what is currently being proposed and those issues need to be resolved between government and parliament. There needs to be transparency in the process for the process to achieve the efficiencies needed to truly transform the healthcare system.
- Delegates at the NHI Bill Dialogue agreed that lessons can be learnt from the kind of efficiencies that have been achieved by the National Health Service (NHS) in the United Kingdom. From the regulatory framework right through to implementation, there are seamless efficiencies that the NHS has achieved.
- Delegates highlighted that the healthcare system we are trying to create should be based on pragmatic solutions that place the needs of the patient first.

### SERIES 2: Fraud, Waste and Abuse Dialogue

*Theme: Fraud, corruption and ethical conduct in healthcare – addressing the moral decay*

**Key highlights from the session:**

- The frameworks for how we deal with fraud, waste and abuse need to be contextualised within what is the health-seeking behaviour of an individual and what the clinician's response is to that.
- Practitioners in both sectors should be monitored.

### SERIES 3: Technology in Healthcare Dialogue

*Theme: Disruptive value-based innovation – shaping the future of healthcare*

**Key highlights from the session:**

- Now with technology, there is a much more personalised understanding of risk management of patients.
- Putting the patient in the middle and empowering the patient; soliciting the patient's experience is not a hard thing to do, but takes a bit of willpower and leadership to do so.

## DELEGATE PROFILE

Those who attended the series of virtual events ranged from CEOs, CFOs, directors and principal officers, to trustees, actuaries and advisors.

The delegate profile included:

- Administrators
- Health funders
- Managed care organisations
- Pharmaceutical companies
- Government departments

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**www.giftofthegivers.org**

## South African Medical Association

The South African Medical Association (SAMA) is a non-statutory, professional association for public and private sector medical practitioners. It functions as a non-profit company registered in terms of the Companies Act as well as a Public Sector registered entity in terms of the Labour Relations Act.

**www.samedical.org · 012 481 2000**

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# Learning Opportunities at the BHF LEADERSHIP ACADEMY

The BHF Leadership Academy launched the following workshops in 2021: A Women Empowerment Workshop; Ethics & Governance Training; POPIA Compliance Training for Medical Schemes and a customised In-house Trustee Development Programme. These workshops aim to equip the sector with essential tools to navigate the constantly evolving and complex healthcare ecosystem and be responsive to the needs of all health citizens.

## Women Empowerment Workshop

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The Women Empowerment Workshop themed *Empowered Women Empower Women – Building networks to accelerate gender equality in healthcare*, was held in October 2021. Over 80 organisations from Botswana, Lesotho, South Africa, Mozambique, and Zimbabwe attended this event. The workshop programme, which featured women who are trailblazers and experts in their various fields within the healthcare space, covered an array of topics around how women can be empowered and empower each other within the workforce.

### KEY HIGHLIGHTS FROM THE SESSION:

- More than 60% of Africa's healthcare workforce and providers are female, and in some cases the figures hit 80%, according to the 2021 Africa Foresight Report. The breakdown shows that 21.7% of white women are in top management positions, compared to 6.8% of black/African women, 2.9% of coloured women, and 5.8% of Indian women. This is one of the issues delegates raised at the recent Women Empowerment Workshop.
- Panellists at the BHF workshop agreed that there is power in networking, but that women often find it difficult to step out of their comfort zones to engage in such activities compared to their male counterparts.

# POPIA Compliance Training Workshop

PROUDLY SUPPORTED BY

In the second workshop held in November, Nick Keene, Director, Solutions Management Work at Microsoft joined Dr Debbie Pearmain, an Independent Legal Consultant, as presenters of the POPIA Compliance Training workshop .

## KEY HIGHLIGHTS FROM THE SESSION

- Digital transformation and cloud transformation are severely hindered if full digital transformation is not realised.
- The healthcare sector and private health industry are very information driven and that makes us responsible for how we implement POPIA.

# Ethics and Governance Training Workshop

PROUDLY SUPPORTED BY

*What is the role of governance in healthcare and why it is important* was the theme of the last workshop on ethics and governance, which was held in November 2021.

This session focused on the role of the ethics and governance framework, as this has never been a more critical era in the South African healthcare system to ensure accountability for continuously improving the quality of care for all.

## KEY DISCUSSION POINTS:

- KING 4 (integrated reporting)
- Why schemes go under curatorship
- Ethics in healthcare: A practitioners guide
- Compliance for schemes – where are the potholes?
- Preparing for COFI and the twin peaks model of governance



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Barloworld Medical Scheme
www.medscheme.co.za

Bestmed Medical Scheme
www.bestmed.co.za

BIMAF WC
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Bonitas Medical Scheme
www.bonitas.co.za

BP Medical Aid Society
www.bpmas.co.za

Building & Construction Industry Medical Aid Fund
www.bcima.co.za

Cape Medical Plan
www.cmp.co.za

Compensation Fund
www.labour.gov.za

CompCare Medical Aid
www.compcare.co.za

Engen Medical Benefit Fund
www.engenmed.co.za

Fishing Industry Medical Scheme
www.fishmed.co.za

Government Employees Medical Scheme (GEMS)
www.gems.co.za

Horizon Medical Scheme
www.medscheme.co.za

Imperial and Motus Medical Aid
www.imperialmotusmed.co.za

Kaelo Prime Cure
www.kaelo.co.za

KeyHealth Medical Scheme
www.keyhealthmedical.co.za

Libcare Medical Scheme
www.libcare.co.za

Makoti Medical Scheme
www.makotihealth.co.za

Medimed Medical Scheme
www.medimed.co.za

Medipos Medical Scheme
www.medipos.co.za

Medshield Medical Scheme
www.medshield.co.za

Nedgroup Medical Aid Scheme
www.nmas.co.za

Old Mutual Staff Medical Aid Fund
www.omsmaf.co.za

Opmed

PG Group Medical Scheme
www.pg.co.za

POLMED - South African Police Service Medical Scheme
www.polmed.co.za

Rand Mutual Assurance
www.randmutual.co.za

Rand Water Medical Scheme
www.randwater.co.za

Rhodes University Medical Scheme
www.rumed.co.za

SABC Medical Aid Scheme
www.medscheme.co.za

SAMWUMED
www.samwumed.org

SEDMED
www.sedmed.co.za

Sisonke Health Medical Scheme
www.sisonkehealth.co.za

Sizwe Hosmed Medical Scheme
www.sizwehosmed.co.za

Suremed Health
www.suemedhealth.co.za

TFG Medical Aid Scheme
www.tfgmedicalaidscheme.co.za

Thebemed
www.thebemed.co.za

The Federated Employers Mutual Assurance Company (FEM)
www.fem.co.za

Tiger Brands Medical Scheme
www.tbms.co.za

Transmed Medical Fund
www.transmed.co.za

Wooltru Healthcare Fund
www.wooltruhealthcarefund.co.za

## ADMINISTRATORS (SA)

Medscheme Holdings
www.medscheme.com

Metropolitan Health Group
www.mhg.co.za

3Sixty Health
www.3sixtyhealth.co.za

Thebe Ya Bophelo Healthcare Administrators
www.thebe.co.za

Universal Healthcare Administrators
www.universal.co.za

## MANAGED CARE ORGANISATIONS (SA)

Dental Health Systems (DENIS)
www.denis.co.za

## BHF AT A GLANCE

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Botsogo Health Plan
www.botsogohealthplan.co.bw

Botswana Public Officer's Medical Aid Scheme (BPOMAS)
www.bpomas.co.bw

PULA Medical Aid
www.pulamed.co.bw

Botswana Medical Aid Society
www.bomaid.co.bw

### ADMINISTRATORS BOTSWANA

Associated Fund Administrators
www.afa.co.bw

### HEALTH FUNDERS ESWATINI

Swaziland Medical Aid Fund
www.swazimed.com

### HEALTH FUNDERS LESOTHO

Mamoth Health
www.mamoth.co.ls

### HEALTH FUNDERS MALAWI

Medhealth
www.medhealth.mw

### HEALTH FUNDERS NAMIBIA

GEMHEALTH Medical Aid Scheme
www.gemhealthmedical.com.na

Napotel Medical Aid Fund
www.napotelmedical.com.na

Renaissance Health Medical Aid Fund
www.rmanam.com

Nammed Medical Aid Fund
www.nammed.info

Heritage Health Medical Aid Fund
www.heritagehealth-namibia.com

### HEALTH FUNDERS ZIMBABWE

Bonvie Medical Aid Scheme
www.bonvie.co.zw

Cimas Medical Aid
www.cimas.co.zw

Generation Health Medical Fund
www.generationhealth.co.zw

Municipality of Masvingo Medical Aid Society

*The BHF takes great pleasure in announcing that the Transmed Medical Fund, Rand Mutual Assurance, Kaelo Prime Cure, KeyHealth Medical Scheme and Bestmed Medical Scheme recently joined the BHF family. We are delighted to welcome these organisations as our newest members.*

# The 21st Annual BHF Conference

Leading change in strengthening our healthcare ecosystem

The Board of Healthcare Funders is committed to hosting the Annual BHF Conference in 2022. Now, more than ever, it is crucial to bring the industry together to address the impact of COVID-19 and other issues affecting healthcare in the region.

**Dates for the 2022 BHF Conference will be announced soon.**


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