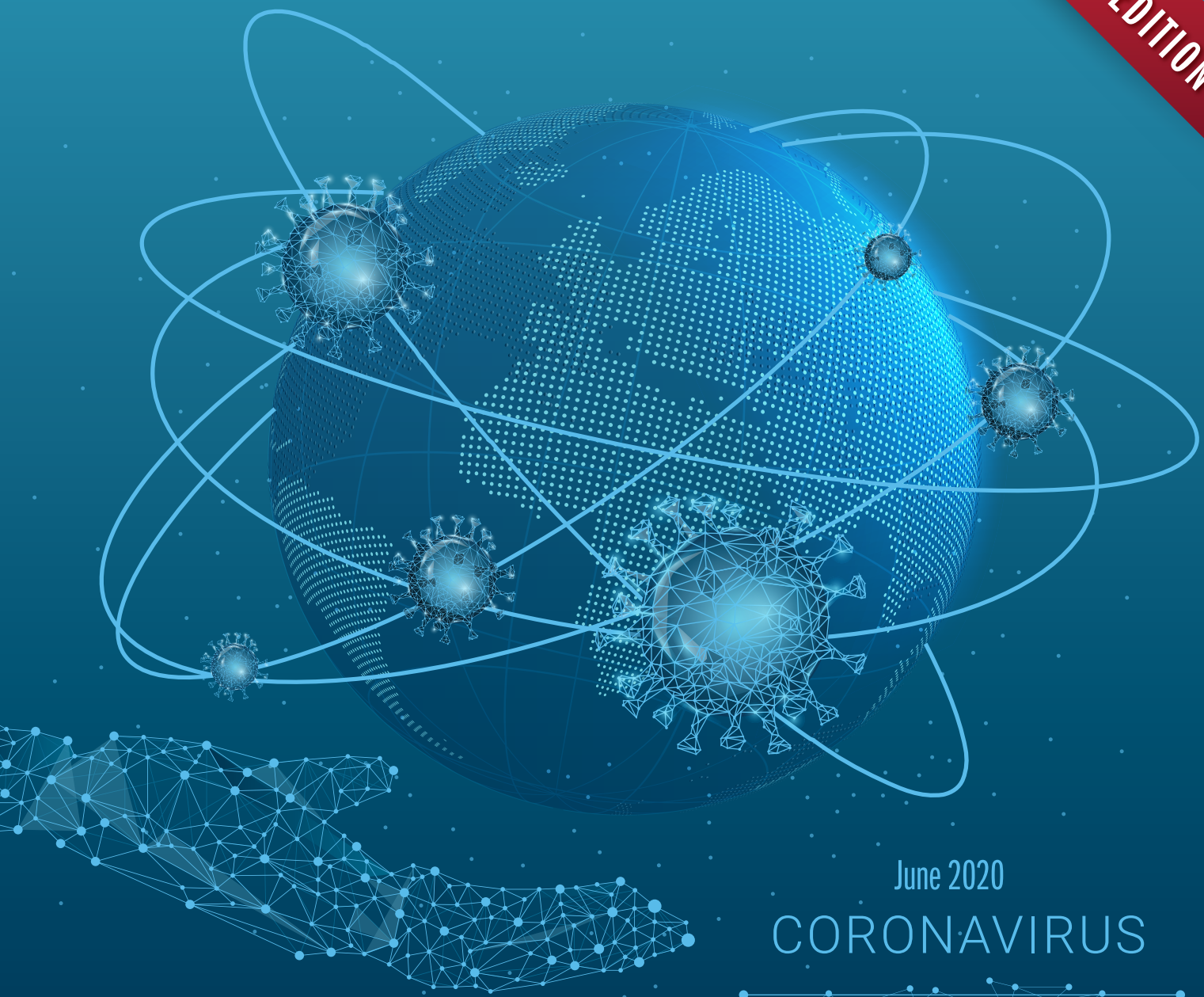
BHF360°

into healthcare

SPECIAL COVID-19 EDITION



June 2020

CORONAVIRUS

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BOARD OF HEALTHCARE FUNDERS

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BHF360°
into healthcare

SPECIAL COVID-19 EDITION

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From the EDITOR'S DESK

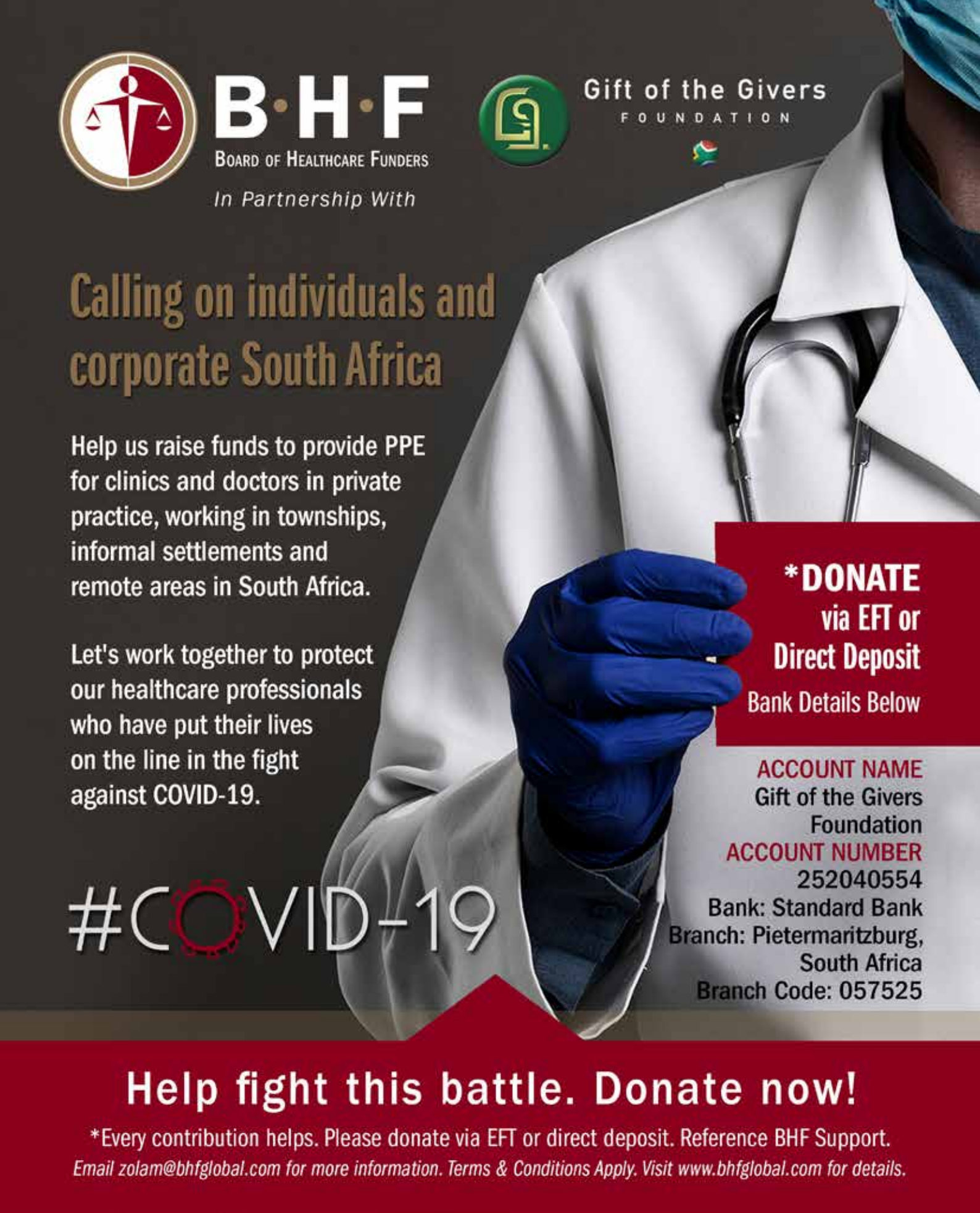
Welcome to this special publication from the BHF in which we look at the unprecedented COVID-19 crisis from a healthcare industry perspective. We hope you find it an interesting and informative read and that it will help inform your response to the pandemic as we navigate these uncharted waters together.

Topics under the spotlight include the following: the different trajectories South Africa is potentially facing as the pandemic unfolds, and the need for models that can test for the variables, even while so much about the virus remains unknown. Addressing COVID-19 effectively will require legal changes in respect of reimbursement, and the BHF's legal department offers some detailed thoughts on this subject. More than ever we need to stand together as an industry. A review of measures taken by a number of BHF members provides an encouraging picture of the industry's participation in assisting the various governments in combatting the pandemic.

An overview of what we have learned so far in the healthcare environment calls, inter alia, for better co-operation and co-ordination between funders and providers. Two contributions focus on the critical role technology can play and the need to harness it effectively, especially telemedicine, a proven modality to enable access to healthcare. It can ensure that healthcare professionals reach more patients, while minimising direct contact.

Enjoy!

Zola Mtshiya
BHF Head of Stakeholder Relations & Business Development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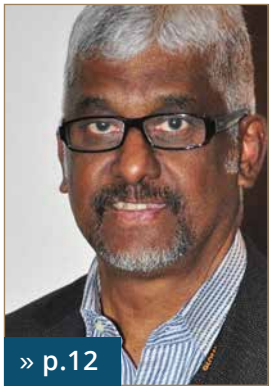
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COVID-19

What we have learned in the

BY CHARLTON MUROVE

Head: Research, BHF

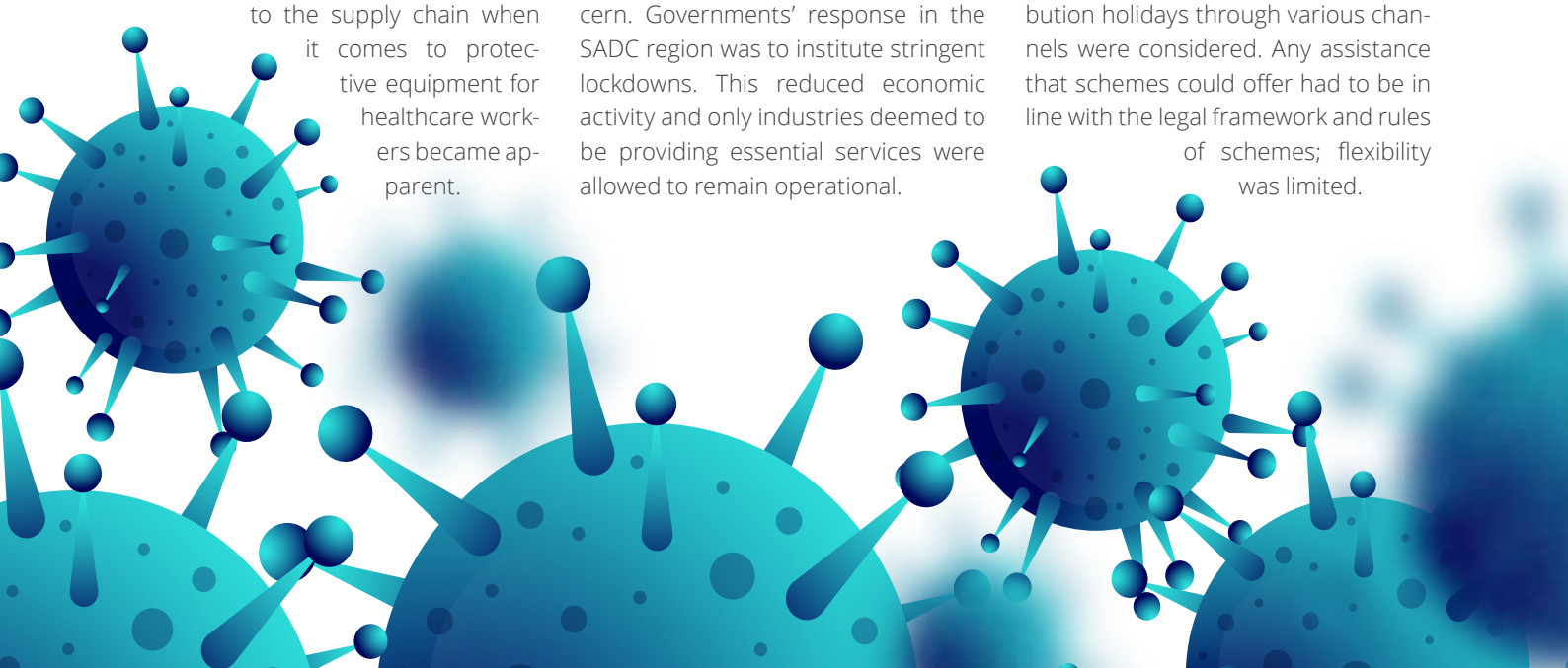
COVID-19 has brought many challenges, chiefly health system challenges. As the news of the pandemic spread across continents, there were many unanswered questions. For example, will our health systems meet the demand for hospitalisations? Suddenly, simple things we took for granted became difficult. Supply of essential medication for chronic patients – will this be available during the pandemic; will we have enough supply and access to much needed essentials? Our vulnerability to the supply chain when it comes to protective equipment for healthcare workers became apparent.

On the funding side, the industry is grappling with questions of sustainability on many fronts. While it was acknowledged that testing for coronavirus was necessary, a single test was initially pegged close to R1 500. To what extend should schemes fund this test for each beneficiary; do schemes have to fund negative tests? Should hospitalisations be necessary, to what extent will schemes be exposed to hospital claims? These are just some of the concerns.

The question of sustainability is broader than just schemes' obligations in respect of healthcare expenditure; retention of membership is also a concern. Governments' response in the SADC region was to institute stringent lockdowns. This reduced economic activity and only industries deemed to be providing essential services were allowed to remain operational.

The idea behind lockdown was to reduce the rate of infection in the hope of not overburdening the health system. Lockdown has greatly impacted a significant proportion of medical scheme members as their income was reduced – and consequently the affordability of medical scheme cover was threatened.

The funding industry considered innovative ways of maintaining cover for beneficiaries as it grappled with the possibility of leaving them without cover in their hour of most need. The industry explored allowing beneficiaries to buy down to cheaper options, and targeted contribution debt or contribution holidays through various channels were considered. Any assistance that schemes could offer had to be in line with the legal framework and rules of schemes; flexibility was limited.



context of medical schemes

Furthermore schemes' ability to extend this helpful hand was limited further by the fall in market values of medical scheme reserves further to global economic decline resulting from the virus. Uncertainty with regard to future claims when virus infections peak did not help the situation, either.

IMPLICATIONS OF A DECLINE IN HEALTH SERVICE UTILISATION

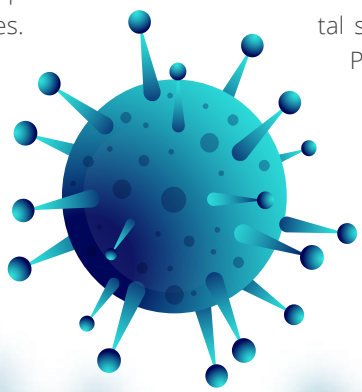
When the lockdown was implemented, there was a large decline in the utilisation of health services, such as hospitalisation, acute medication and consultations with healthcare professionals. The extent of the decline varied across disciplines and medical schemes. Some schemes reported a more than 50% drop in hospitalisations. This could largely be linked to decisions by various professional bodies and hospital groups to suspend admissions for elective procedures, as providers grappled with how to deal with potential COVID-19 patients while preparing for an impending flood of hospital admissions during the virus's peak period, as was witnessed in most parts of Europe and the USA.

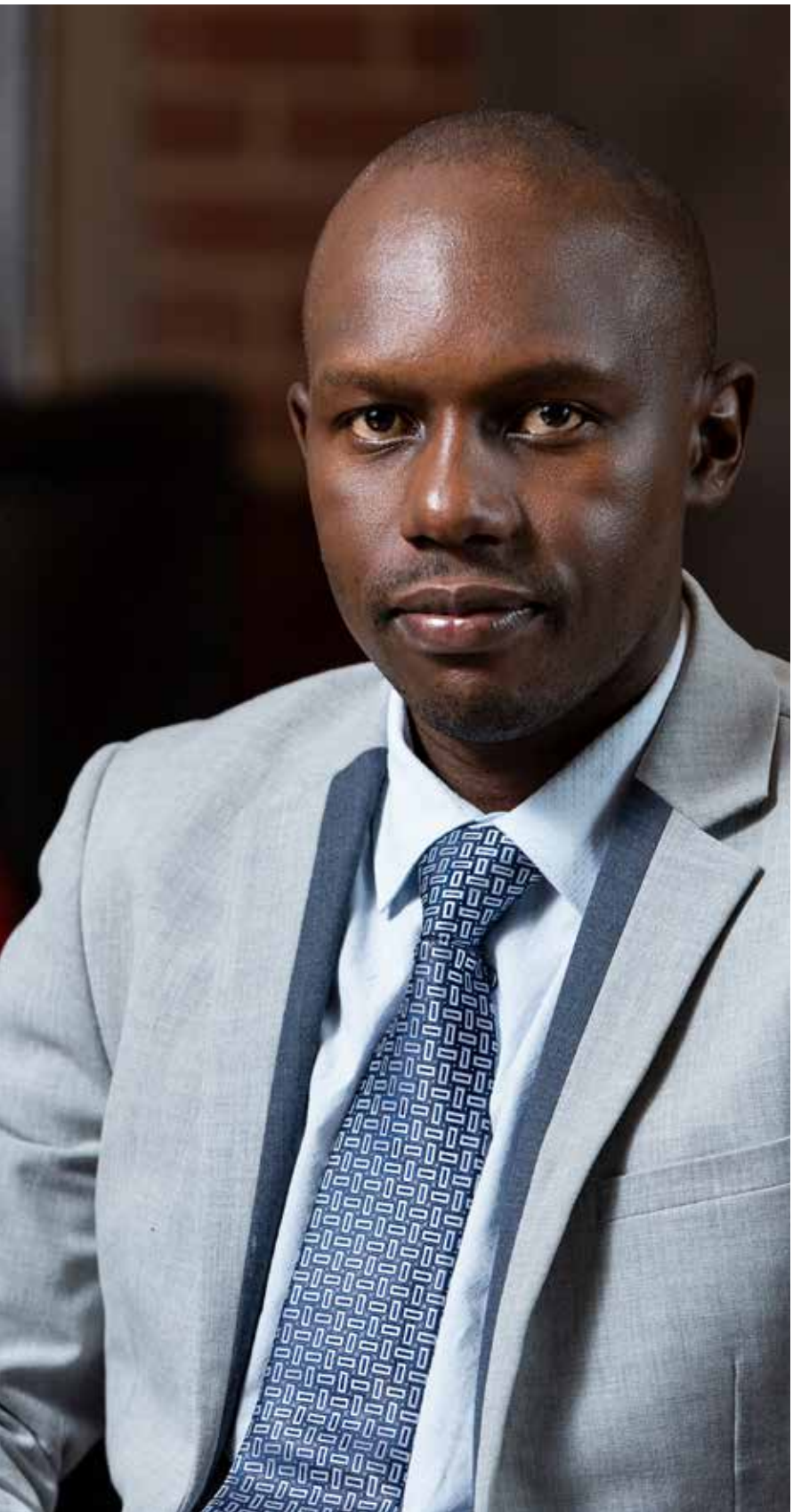
This decline in usage of healthcare services can also be attributed to patient factors. There was probably general reluctance to access health services for fear of acquiring infection at facilities. News reports of entire hospitals being closed due to multiple COVID-19 cases among hospital staff did not help either. Patients even avoided visiting their GPs as reports spread of certain practitioners being infected by other patients.

A ROLE FOR TELEMEDICINE

This fear of spreading the virus when patients access care led to significant pressure on regulatory bodies to introduce long-awaited telemedicine measures. South Africa had not yet adopted telemedicine, and this is an opportune time as it ensures the protection of both practitioners and patients while maintaining access to care. It is introducing a new dynamic in how care is accessed across the country – helping bridge the gap in the supply of healthcare professionals, which is disproportionate relative to geography. Health funders quickly embraced the development and are paying for telemedicine consultations.

Another positive on the regulatory front was the Competition Commission's suspension of collective bargaining in the treatment of COVID-19. This was once again a reflection of the unbal-





anced regulatory framework that places funders at a disadvantage when it comes to negotiating fair prices for health services. At the time of writing, however, there was not much movement on a negotiation framework or platform to allow for collective bargaining for COVID-19 treatment. This is despite the expectation that funders should pay in full for COVID-19 treatment.

The fall in utilisation of health services brought challenges for private healthcare providers, both facilities and individuals. They depend on regular income from health funders as patients access care, yet had to remain operational during the lockdown while receiving reduced income – this put great financial pressure on them. The cost of running facilities increased as extra cautionary measures had to be in place to manage the potential transmission of the virus.

Providers were not spared the financial impact of this, with some approaching funders for advance payments. Obviously, this was not extended as funders' regulatory frameworks do not allow for such payments.

What the coronavirus pandemic has also highlighted is that the preferred method of reimbursement (fee-for-service) has some risks associated with it.

Healthcare providers only earn income when a patient accesses services. If providers had a mix of fee-for-service and alternate reimbursement models, like global fees for facilities and capitation, their incomes would have not fallen as much as they did. In addition, funders would have been able to predict with more certainty the impact of the virus on healthcare expenditure. This reduction in uncertainty would have made funders more flexible in how they responded to the pandemic.

CHARLTON MUROVE
Head: Research, BHF

THE NEED TO ELIMINATE UNNECESSARY UTILISATION

The fall in health services usage levels also brought other issues to the fore: to what extent is the decline due to a drop in unnecessary utilisation (waste in the system) and denial of access to patients who genuinely need it? Obviously, the response to these two possibilities is quite different, but what is needed is a better knowledge of how patients access care.

Wastage should be eliminated as much as possible and this will need a multi-pronged approach that takes into account benefit design, patient education and managed care interventions. The debate about the extent of supplier-induced demand in the market will widen, given the coronavirus experience.

Patients who fail to access care as a result of the restrictions present a big risk to the industry. In most cases, delayed access leads to complications, which often require more intensive and expensive interventions. In other cases, patients will pay the ultimate price – their lives. Perhaps more care should have been taken before the lockdown to ensure the availability of appropriate care and access. This might have helped mitigate healthcare providers' loss of income.

CHALLENGES RELATED TO FRAUD, WASTE AND ABUSE

The fall in economic activity also brings challenges relating to fraud, waste and abuse. Internationally there are already reports of how fraudsters are taking advantage of the pandemic and devising methods to defraud patients and funders. South Africa is likely to see similar trends. Vigilance on the part of funders and patients will be key to ensuring trust funds are protected. Monitoring of telemedicine is critical as this new platform may easily be abused.

Perhaps what is needed is better coordination between providers and funders. They depend on each other to provide effective patient care. The restriction on collective bargaining took away the platform often used to discuss health system challenges, a discussion needed in the private sector.

The relaxation of the lockdown by the South African government brought more challenges. After five weeks of strict social distancing and depressed economic activity, it was apparent that the lockdown had to be relaxed. The impact of those five weeks on the economy was huge – return to work was essential. This was despite evidence on the health front that the number of new infections was continuing to grow. The number of daily cases was higher than just before the lockdown.

Healthcare facilities and professionals were faced with tough choices and had to open, despite evidence of expanding infection. This was unfortunately done in an uncoordinated way; there was not much communication between providers and funders on how to return the industry to normal. There were also requests from providers for schemes to fund all protective equipment, as well as the testing of all patients admitted to hospital for COVID-19. While there is merit to such testing, very little assurance was provided to funders with regard to patient safety. Measures to limit the spread of the virus were not standard across facilities; neither were they communicated. Thus, there was no assurance offered to the funders on the safety of patients accessing facilities.

Perhaps what is needed is better coordination between providers and funders. They depend on each other to provide effective patient care.

The restriction on collective bargaining took away the platform often used to discuss health system challenges, a discussion needed in the private sector. Failure to coordinate between funders and providers led to various complexities like lack of standardised coding in the industry. The response to the virus has been compromised at least partly due to the lack of such coordination.

THE POWER OF COLLABORATION

A tool for progress in curbing the pandemic

Due to the international nature of COVID-19, collaborations are required at global, national and community levels. In this article we outline the tools that enable these and the coordination of efforts to protect the public health at these levels.

CO-WRITTEN BY DR TRYPHINE ZULU, DR STANLEY MOLOABI AND DR. SELAELO MAMETJA GEMS

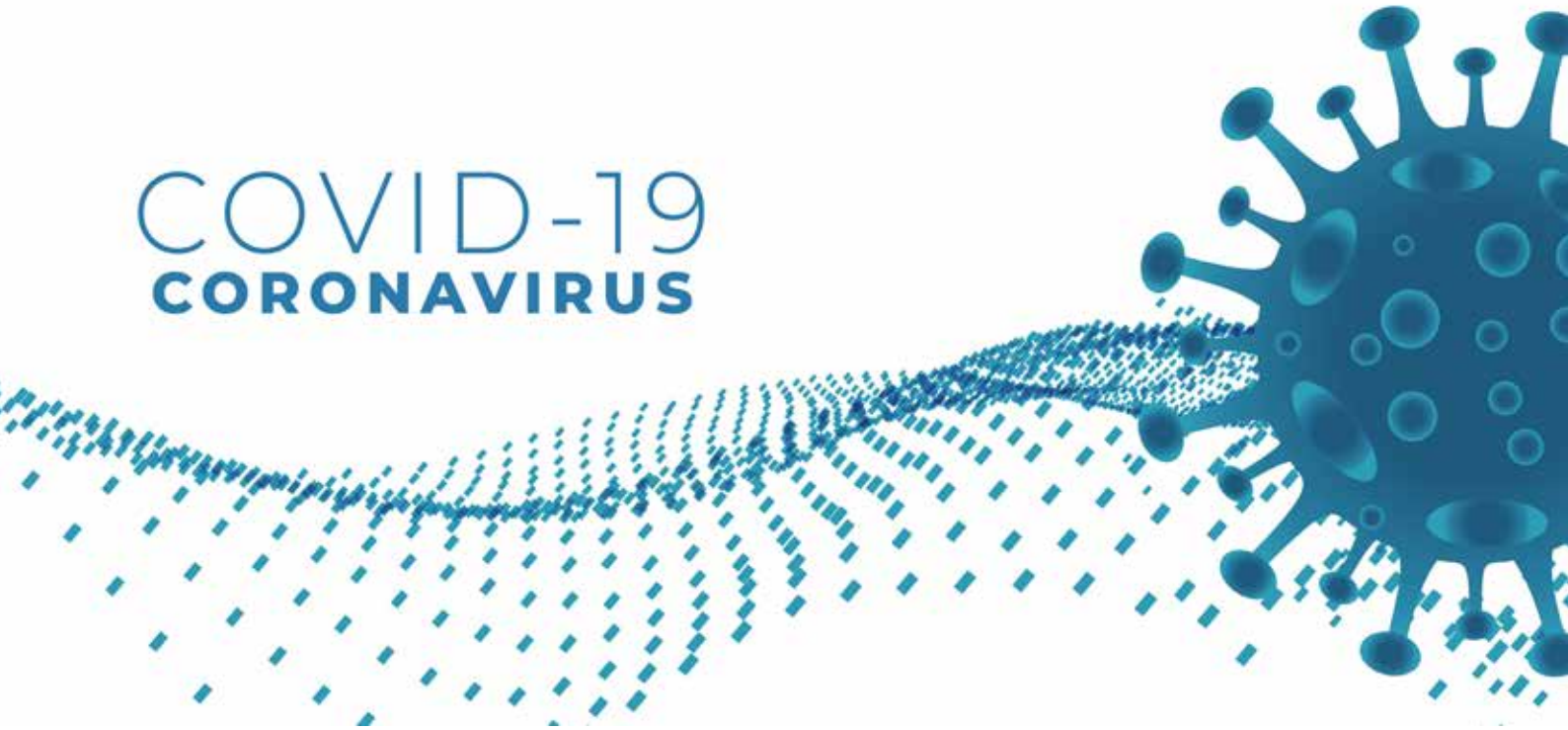
On 31 March, the World Health Organisation (WHO) declared COVID-19 a public health emergency. According to the WHO, a public health emergency is the occurrence or imminent threat of an illness or health condition caused by bioterrorism, epidemic or pandemic disease, or a novel and highly fatal infectious agent or biological toxin that poses a substantial risk of a significant number of human fatalities or incidents, or permanent or long-term disability.

THE INTERNATIONAL HEALTH REGULATIONS (2005)

The International Health Regulations (2005) (IHR), adopted by the World Health Assembly in 2005, provide a legislative framework for collaboration at international level. This document is binding on all WHO member states and provides a regulatory framework for global management of public health emergencies.

The purpose of the IHR is to prevent and manage the public health risks arising from the worldwide spread of disease. These regulations require countries to notify the WHO of their emerging public health threats, obliging them to develop, strengthen and manage capacity to identify, assess, report and respond effectively to public health risks and emergencies. These regulations also empower the WHO to make non-binding and temporary recommendations for affected countries.

The Pandemic Influenza Preparedness Framework (PIP Framework) adopted by the World Health Assembly in 2011 provides essential guidance on influenzas with human pandemic potential. It encourages WHO member states to share PIP biological materials from influenza viruses in a rapid, systematic and



timely manner, through the Global Influenza Surveillance and Response System, which is coordinated by the WHO. For example, manufacturers of influenza vaccines, as well as diagnostic and pharmaceutical companies, will receive samples from the surveillance Bio-Bank. There are also benefit sharing arrangements with for-profit organisations, which will receive samples from the PIP framework.

NATIONAL PUBLIC HEALTH EMERGENCY TOOLS

South Africa has two pieces of legislation to protect the public in case of serious harm to health and life. These are the State of Emergency Act no. 64 of 1997 and the Disaster Management Act no. 57 of 2002. While both these laws provide for the protection of life, they differ significantly.

The State of Emergency Act is much more stringent and can only be applied if there is the necessity to restore peace and order as well as a threat to life.

In the middle of March, the president declared a national state of disaster. This declaration was enabled by the Disaster Management Act. A disaster is defined as a progressive or sudden, widespread or localised natural or human-caused occurrence that causes or threatens to cause death, injury or disease; damage to property, infrastructure or the environment; or disruption of the life of a community. The effect is of a magnitude that exceeds the ability of those affected to cope with its effects using only their resources.

A disaster management plan is a continuous and integrated multisectoral, multidisciplinary process of planning and implementation measures aimed at (a) preventing or reducing the risk of disasters; (b) mitigating the severity or consequences of disasters; (c) emergency preparedness; (d) rapid and effective response to disasters; and (e) post-disaster recovery and rehabilitation.

The most crucial function of disaster management is to mobilise financial resources to mitigate the effect of a pandemic. Furthermore, the act allows for the relief of persons affected as well as for the movement of people and goods, and the availability of goods and services. These provisions primarily make it possible to implement and enforce public health measures such as travel restrictions, lockdowns, social distancing and rapid upscaling of health services.

Ministers may also issue regulations, directives and notices that are specific to COVID-19. To date, more than 50 have been published, and it is impossible to summarise them in this article. Within the health funding sector, the Council for Medical Schemes (CMS)

issued several circulars to guide management and funding of COVID-19.

Other measures deal with the exemption of the industry from sections 5 and 6 of the Competition Act, and HPCSA guidelines on telemedicine (allowing telephonic consultations). The fact that the legality of circulars has previously been questioned adds another level of uncertainty on the preparedness of the industry to deal with public health emergencies.

The government is effectively using national health regulations on communicable diseases to coordinate surveillance of COVID-19 in both the public and private sectors. Tools that have been used include regulatory decisions, circulars and guidelines. In terms of mobilising resources for healthcare, the CMS has issued a circular outlining how COVID-19 ought to be funded and has submitted the gazette to the Minister of Health. The HPCSA, on the other hand, has relaxed its rules on telemedicine to allow practitioners to consult with patients remotely by electronic means.

COMMUNITY-LEVEL MEASURES

Not only has government coordinated efforts at a national level, South Africans at large have brought their contribution to the table by voluntarily donating money, services and other contributions in kind. The solidarity fund is an example of how South Africans come together during adversity.

In typical South African fashion, society also prescribed humour, the best medicine, for itself, accepting with grace and laughter the partial lifting of the lockdown further to the President's 'mask event' at the end of his address. South African fears with regard to the reopening of schools were also leavened with humour. Concerns included children losing their masks, sharing their masks and poor cough etiquette.

IMPLEMENTATION CHALLENGES

Pandemics are notorious for exposing weaknesses in the health system. While the Health Market Inquiry (HMI) had identified some in the private health sector, these issues are now more clearly visible. High costs, for example, are a considerable barrier to diagnosis, treatment and care of COVID-19 patients, including the tracing of contacts.

Despite promulgation of enabling legislation, there are still many challenges. Although the cost of tests has been lowered, they are still unaffordable, especially if the funding industry has to follow a national strategy of extensive screening and testing for COVID-19.

At the time of writing, negotiations on the hospitalisation of COVID-19 patients in the private sector were underway. The sector has excess bed capacity, and this could be used effectively to supplement bed shortages in the public sector. There has to be agreement on price, though. The nosocomial outbreak of COVID-19 in private hospitals has also been a cause for concern.

South Africa has a high density of private hospitals and from the outset, the hospital groups should have designated several hospitals for COVID-19 only and allowed others to continue with the provision of routine care. This would have assisted with infection control and allowed for the continuous provision of healthcare.

When the virus broke out in China, that country upscaled the local production of personal protective equipment (PPE) for medical personnel. This domestic production not only reduced costs but also made PPE widely available while boosting economic activity. There is no evidence locally of national efforts to increase capacity and negotiate affordable PPE, except in respect of the provision of cloth masks. Localising production of COVID-19-related healthcare products and medicines would contribute towards stimulating the economy.

"If you want the cooperation of humans around you, you must make them feel important, and you do that by being genuine and humble." Nelson Mandela

> **Perhaps it is high time to negotiate an alternative reimbursement mechanism that incentivises the holistic management of COVID-19 patients.**

DR. SELAELO MAMETJA
Chief Research Officer, GEMS

While there is no specific treatment for COVID-19 as yet, other therapies are recommended off-label or in the trial setting. Access to medicine for all is essential. While the single exit price exclusions are not applicable in the public sector, allowing the private sector to purchase medicines at a tender price or negotiated tariffs during the outbreak would be beneficial. While the Competition Commissioner has allowed some exemptions, the Medicines and Related Substances Control Act no. 101 of 1965 rigidly regulates the price of medicines.

While the CMS has indicated that the funding of COVID-19 complications/severe COVID-19 is a prescribed minimum benefit, there is much uncertainty on the management of patients with mild symptoms and those who cannot isolate safely. Guidelines are necessary to guide the management of these patients. Considering the HMI findings and the cost of private healthcare, there is a risk that medical schemes may find it unaffordable to fund the care of this group.

The risk can be mitigated in two ways: (a) private health facilities can isolate healthy patients at low cost (these patients require minimal clinical care) thus making it affordable for schemes to purchase isolation services; or (b) the state can provide such facilities. However, the latter strategy may result in the displacement of vulnerable patients.

The pandemic is also highlighting other deficits in the current private health system. With fee-for-service, there will be more disjointed efforts in community screening, contact tracing and referrals. Perhaps it is high time to negotiate an alternative reimbursement mechanism that incentivises the holistic management of COVID-19 patients. In-hospital infection control measures require routine screening and testing for COVID-19. It is not apparent who should fund this, particularly with regard to nosocomial COVID-19.

According to the National Health Act regulations that deal with notifications of communicable diseases, schemes should report these to the National Institute for Communicable Diseases (NICD). To date, there has been no guidance on how schemes should do this. Claims information contains rich data that can be used to inform the pandemic response appropriately.

Furthermore, the pandemic has highlighted the weaknesses of a fragmented and inequitable health system. South Africa has sufficient resources in the private sector. The reasons for the collaboration of the public and private sectors have never been more compelling, and perhaps represent an opportunity for government to take on the role of a giant price negotiator on behalf of the funding industry – a nice practice run for its strategic purchasing role under the NHI? The volumes bought by the public sector could incentivise the private healthcare industry to provide competitive pricing. The time to show that we can do universal healthcare is now.

TELEMEDICINE
Enabling access for all

During a time of crisis, telemedicine has helped healthcare provider organisations and caregivers better respond to the needs of patients.

In less than a decade there have been several global public health crises: SARS, MERS, Ebola, Zika virus and now COVID-19. We have already seen the benefits and importance of telemedicine for COVID-19, which the pandemic has brought into a new light. This is why healthcare stakeholders should embrace the technology and make it an integral part of the system to allow us to prepare for another global health crisis.

Telemedicine is a readily available solution that allows those following treatment for other conditions to continue doing so, while potential COVID-19 cases can be filtered out remotely. It has been available for a long time but not widely adopted, and entails the use of information and communication technology to provide patient care and the sharing of clinical information between different locations.

Clinical applications of telemedicine include teleconsultations, telecardiology, telegynaecology, and mental health consultations. It does, however, carry some challenges and limitations, e.g. with regard to surgery and anaesthesiology.

As the coronavirus wreaks havoc on the healthcare system, telemedicine is helping healthcare provider organisations and caregivers better respond to the needs of patients. It enables the transfer of health information across distances using technologies like email, telephony, video links and social networks. In this way, telemedicine is bridging the gap between people, physicians and health systems, allowing everyone, especially asymptomatic patients, to stay at home and communicate through virtual channels, helping to reduce the spread of the virus to populations and frontline medical staff.

Globally and in South Africa telemedicine is facing certain legal, regulatory and reimbursement challenges, but there is nonetheless a need to facilitate more widespread adoption thereof.

In March 2020, the Health Professions Council of South Africa (HPCSA) added a relaxation clause to the telemedicine rules, allowing its use during the crisis. This allowed patients to be managed remotely as the country went into lockdown. We are hopeful that telemedicine will continue to be permitted after the crisis.

IMPROVING ACCESS TO HEALTHCARE

The telemedicine surge during the COVID-19 pandemic is helping to provide care to patients who might need it after exhibiting potential symptoms of coronavirus infection.

Telemedicine is presenting itself as the ideal solution in this regard, linking patients remotely to hospitals, primary care and consulting disciplines, thus allowing access to healthcare while curbing disease spread. Telemedicine solutions and

programmes allow people suffering from other medical ailments during this time to receive care from home without entering medical facilities, minimising the risk of their contracting the virus.

The CDC and the WHO are urging both the general public and medical staff to use telemedicine solutions for non-urgent communications in order to reduce the pressures on emergency rooms and clinics. Telemedicine is being used to 'forward triage' patients long before they arrive at primary care facilities.

Many chronic care patients can schedule teleconsultations with their doctors to fill prescriptions and avoid face-to-face visits, hence minimising their risk of exposure to COVID-19. Chronic medication can be delivered to patients' homes. This allows for continuity of care. This digitalisation of healthcare is streamlining things like the dispensing of medication, record-sharing and patient-tracking.

Telemedicine has proven to be a crucial lifeline for some rural communities, helping to address workforce shortages and reducing the burden on patients who might otherwise have to travel long distances for healthcare services. This is particularly important in respect of healthcare professionals unavailable in rural areas, e.g. psychiatrists and consulting specialists.

Telemedicine also allows rural hospitals to outsource diagnostic and other services and thus help reduce providers' sense of isolation. It provides a 24/7 lifeline between patients and providers. There is also a rapidly increasing need for on-demand acute care via telemedicine.

Three primary roles of telemedicine during the crisis

1. Simple screening of patients remotely, rather than requiring that they visit a practice or hospital;
2. Triage of patients with cold and flu symptoms, and remote care for those who do not need medical intervention or could receive care at home;
3. Routine care for patients with chronic disease and on-demand acute care to reduce risk of exposure to the virus; and
4. Protection of providers and staff from repeated exposure to infected patients.

Limitations of and possible pitfalls of telemedicine

1. The treating practitioner may not be able to obtain a full clinical picture from a remote location, so issues may arise as a result of this limitation;
2. Incorrect prescribing; and
3. Missed diagnoses, as these are now reliant solely on a history and reported symptoms without a physical examination.

Although telemedicine is evolving fast and is a proven modality to enable access to healthcare, it is important that it is used appropriately, and its use should not compromise patient care. Telemedicine oversight is therefore essential and this is the responsibility of the HPCSA. ■

BY PROFESSOR MORGAN CHETTY
CEO, KwaZulu Natal Managed Care Coalition, The IPA Foundation of SA

LEGAL CHANGES

aimed at addressing the COVID-19 pandemic

On 15 March 2020, the government declared the COVID-19 outbreak to be a national disaster in terms of the Disaster Management Act, 2002 (DMA), which is administered by the Minister of Co-operative Governance and Traditional Affairs.

Section 27(2) of the DMA allows the Minister to make regulations, issue directions or authorise the issue of directions concerning matters listed therein only to the extent that it is necessary for the purpose of:

(a) assisting and protecting the public;
(b) providing relief to the public;
(c) protecting property;
(d) preventing or combatting disruption; or
(e) dealing with the destructive and other effects of the disaster.

At the time of writing, the latest regulations in terms of the DMA were those promulgated by the Minister for alert level 3 on 28 May 2020. They amend the alert level 4 regulations published on 29 April.

A decision of the Pretoria High Court had held that businesses do not need to obtain a Companies and Intellectual Property Commission (CIPC) certificate in order to conduct any business during the state of disaster. The court held unequivocally that no law enforcement officers should request a CIPC certificate from anyone and set aside the directives of the Minister of Small Business Development in this regard.

The regulations stipulate that an employer must provide every employee who may come into direct contact with members of the public as part of their duties with a cloth face mask to cover their nose and mouth, or a homemade or other appropriate item that covers the nose and mouth when in a public place.

No-one is allowed to be in a public place or enter a public building or premises if not wearing a cloth face mask.

The regulations also cover attendance at funerals, prohibitions on evictions, places and premises closed to the public, the sale, dispensing or transportation of liquor and the operation of the economic and public sector.

Employers are required to promote physical distancing of employees, including enabling them to work from home or minimising the need for them to be physically present at the workplace. Employers must restrict face-to-face meetings and take special measures for employees with known or disclosed health issues or comorbidities that place them at a higher risk of complications or death arising from COVID-19.

No-one who is a clinically or laboratory-confirmed case of COVID-19, who is suspected of having contracted COVID-19, or who has been in contact with a carrier of COVID-19 may refuse to submit to a medical examination, including the taking of a body sample.

In May and early June court cases against the regulations were heard and some, like the court case challenging the ban on tobacco products,

are still to take place. In early June, the North Gauteng High Court set aside the regulations under alert levels 3 and 4 as unconstitutional, but suspended its order for 14 days to give the government the opportunity to rectify the regulations.

The government decided to appeal this decision, which has the effect of suspending the judgement pending the appeal. Therefore, the regulations are still applicable as at the time of writing.

USEFUL LINKS

- The COVID-19 regulations issued on 29 April 2020 can be accessed at https://www.gov.za/sites/default/files/gcis_document/202004/43258rg11098gon480.pdf .
- The COVID 19 regulations made on 28 May for alert level 3 can be accessed at: https://www.gov.za/sites/default/files/gcis_document/202005/43364gon608s.pdf
- The NICD guidelines can be found at https://www.nicd.ac.za/wp-content/uploads/2020/04/COVID-19-Quick-reference-v12-09.04.2020_final-1.pdf

COVID-19 is now a prescribed minimum benefit in terms of the Medical Schemes Act, for the period of the pandemic. Medical schemes are therefore legally obliged to pay for testing and screening for COVID-19, as well as treatment and rehabilitation. Private hospitals are insisting on COVID-19 tests for patients being admitted for elective surgeries, even when there is no clinical evidence to suggest infection.

A number of medical schemes have objected to paying for such tests and indeed they are not part of the prescribed minimum benefits. Other schemes have said that members may have a limited number of COVID-19 tests, regardless of whether they are symptomatic or not. Some scheme members may find themselves paying for pre-admission COVID-19 tests depending on the rules of the scheme in question.

The National Institute for Communicable Diseases (NICD) has issued guidelines for when a person must be tested for COVID-19. Only persons with acute respiratory illness with sudden onset of at least one of the following should be tested: cough, sore throat, shortness of breath, or fever or history of fever. The NICD therefore does not recommend testing of persons who are asymptomatic.

The Disaster Management Act puts a three-month time limit on the declaration of a disaster. The current declaration is due to expire in the middle of June 2020. However, the government is allowed to extend it for periods of one month at a time and has already indicated its intention to do so. ■

BY DR. DEBORAH PEARMAIN
Independent Legal Consultant

LOOKING INTO THE CRYSTAL BALL

trajectories for South Africa over

The trajectories for South Africa do not present alternative pathways that trade off lives against the economy. All possible futures impact on both lives and the economy.

BY DR SHIVANI RANCHOD
CEO, Percept

COVID-19 has stripped away the illusion of certainty: there is no room for denial. After months of the world's grappling with the disease, we still face many unknowns: the precise physiological dynamic, the proportion of people who are asymptomatic, the length of incubation, the inter-relationship with co-morbidities, the duration of immunity and the extent of the economic consequences. We still await scientific confirmation of key questions: will any of the vaccines work, will the many treatments being tested prove successful, and does the BCG vaccine have some protective effect?

Even when considering two simple disease trajectories for the country: the hare and the tortoise, the precise ways in which we might respond is unknown. In the hare trajectory, we experience an exponential increase in COVID-19 cases and deaths. This is plausible given our high population

density, an immune-compromised population and the cooling of temperatures. Regardless of whether we revert to higher levels of economic restriction, there is likely to be an economic impact as companies close to prevent the spread among their staff and people voluntarily stay home out of fear.

Alternatively, we may find that the impact on South Africa is more muted than the experience in Europe and the United States (the tortoise). This is plausible given the youth of our population.

Epidemiological modelling, like that undertaken by the Actuarial Society, allows us to test the ways in which the direct impacts of the disease may unfold. Even this is fraught with all the limitations inherent in using models as representations of reality; hence there is a need for a model where different combinations of variables can be tested.

SHORT- AND LONG-TERM IMPLICATIONS

The trajectories for South Africa do not present alternative pathways that trade off lives against the economy. All possible futures impact on both lives and the economy. In addition

the next 12 months

to official COVID-19 deaths, there are also deaths from other causes that have been misclassified, preventable deaths from other causes due to inability to access an overburdened health system and the mortality impact of economic shock (though there is little evidence from previous recessions that this is substantial).

Part of the difficulty associated with thinking through future trajectories is that some of the implications are short term (ICU utilisation and deaths), while others are long term (such as the impact of school closures on educational outcomes and the permanence of job losses).

The intrinsic uncertainty of the disease trajectory is compounded by the wide range of responses to our reality. Some of these responses lie outside our control – in a global world we are affected not only by our borders, but also our trade decisions and our own recession.

Within our borders, the impact depends on government's responsiveness, the effectiveness of that response's implementation, the heeding of human rights and the myriad of complex trade-offs and decisions.

The response of individual South Africans is also crucial: will we continue to abide by restrictions, how will individual businesses trade off commercial concerns against the safety of their staff and customers, and will we innovate in extraordinary ways?

A best-case future sees continuous investment in our health system to avoid its becoming overwhelmed. Strong and clear leadership is needed to ensure that the economic consequences are not chaotic, and relief reaches the most vulnerable. Cycling between high and low levels of restrictions may prevent the system from being overwhelmed – but we have to recognise that this will get more difficult to sustain over time.

A worst-case future sees us fare worse than the global north because both our health system and economy are more fragile, we have fewer health workers and access to healthcare in rural parts of the country is poor.

A health system collapse will have an impact not just on patients but also on health workers. Weak leadership exacerbates the situation by not being sufficiently responsive and clear. Social tensions are high.

COVID-19'S IMPLICATIONS FOR HEALTH SYSTEM REFORM

COVID-19 has given us a glimpse of what is possible for health system reform: rapid innovation in digital access to health, the deployment of community health workers to accelerate our response, home delivery of medicines in the public sector and private sector doctors willing to roll up their sleeves for the public good.

The centrality of stewardship is beyond question. There are many things that would have made our health system more resilient but are missing because of lackadaisical regulation and oversight. Imagine if we had progressive telehealth regulations, risk-based capital and a risk equalisation fund. Imagine if we had strong purchasing of healthcare on the basis of value and could purchase easily from public and private providers.

The decisions about how to rebuild our economy, health system and social structures will have a long-lasting impact. We need leadership that is agile and responsive, that is sufficiently devoid of ego to admit where reversals in decisions are warranted, and that nurtures solidarity and trust. ■

DIGITAL TECHNOLOGY

can help Africa combat COVID-19 in unprecedented ways

This digital transformation precipitated by the COVID-19 pandemic will only work if bold steps are taken to disrupt, diffuse and democratise our health systems.

BY PRECIOUS MATSOSO AND STEVEN DAVIS
Co-chairs: WHO Digital Health Technical Advisory Group

The COVID-19 pandemic accentuates the digital divide and technology gaps across Africa, but digital technology nonetheless offers unprecedented opportunities for combating the virus and improving well-being across the continent.

A plethora of digital tools have been deployed across every aspect of the pandemic – reaching a wide range of people: WhatsApp messaging options for citizen engagement and social connections; competitive meeting solutions for all types of business and social gatherings; and online education tools, webinars and Bing-streaming television. The pandemic has sparked innovation and forced adoption of these tools at unprecedented speeds. They have ensured that work continues even under the most difficult circumstances – with proper social distancing and effective remote operations.

INNOVATIVE TOOLS TO FACILITATE INFORMATION-SHARING

The lockdowns and semi-lockdowns across the world have forced countries to rely on digital tools and information models that use complex and robust tools that work across multiple sources and capabilities. The trajectory of the pandemic has revealed the extent to which countries and the world are willing and able to digitise and collaborate. For instance, the Commonwealth has developed a COVID-19 tracker, a tool designed to collect real-time data for governments, and a portal information-sharing and health protection toolkit for health professionals.

Professional organisations have shared best practices on health protection measures to support them in the care of patients.[3] The African Union, through the Africa CDC's working in partnership with the WHO, has become an important information source for COVID-19.[4] The WHO is set to launch a COVID-19 digital clearing house to provide more information on useful and effective digital tools already being used across the globe to combat the pandemic, so that Ministers of Health and other health authorities do not have to re-invent solutions time and again.

While the opportunities afforded by new digital and data tools are immense, they are not deployed consistently, uniformly or equitably across the continent or the world. The pandemic is shining a spotlight on the underlying systemic challenges and inequities in our healthcare systems and digital ecosystems. For example, the response to outbreaks requires good surveillance systems and well-functioning health information systems, which are essential building blocks of any health system. Despite sound measures, these systems are still under-resourced and underdeveloped in many countries and regions. In addition, in some countries, surveillance and close monitoring have been achieved at the expense of the protection of personal privacy. Any attempts at surveillance must focus on chasing the virus - not individuals, and the tracking and tracing of cases - not victimising or stigmatising those affected.

The third global survey conducted by the WHO in 2015 investigated how digital health tools can support universal health coverage.[5] Even though most countries had eHealth and/or ICT strategies and plans, these did not necessarily translate into adequate systems for information-gathering, or organisations for integration into a network of resources that can help with the clinical management of patients, management of health facilities, disease surveillance and more. These disparities and inconsistencies are particularly visible when we look at the digital health capabilities of the 54 countries in Africa.

According to the International Telecommunications Union, as of October 2019 there were 4.1 billion internet users and of these 525 million were in Africa.[6] Infrastructure and data costs have proven to be barriers to effective use of internet technology for broad health purposes. Nonetheless, the potential for the use of mobile phones for public health purposes should not be discounted in the COVID-19 response and recovery. Mobile applications and tools for tracking and tracing cases, sharing information with citizens, supporting health workers and volunteers, managing supply chain issues, and creating communities of support to address mental health and other COVID-19-related issues are proving effective across the world.

Other digital innovators are focusing on using mobile devices and other digital tools to ease the burden on health

THE 2020 DIGITAL REVOLUTION

Nowhere has this digital revolution been more apparent than in the global and regional health sector. Worldwide estimates of COVID-19 cases reached 3.1 million, with 217 000 deaths by the end of April[1]. As at 28 April a total of 33 237 cases and 1467 deaths had been reported in Africa[2]. Leaders and everyday citizens have had real-time access to information about the novel coronavirus and its spread. With powerful use of data analytics, a continuous feed of data from various sources has provided updates on daily infections and mortality. Citizens across the continent and the globe have been tracking the progress of our massive campaigns to 'bend the curve' of this health crisis.

systems. As the pandemic continues to move across Africa, all these ideas must be explored and, if safe, effective and affordable, expanded for extensive use.

FOCUS ON OPTIMISING TECHNOLOGY USE

It is time we accelerate the use of this unprecedented arsenal of digital tools not only to combat COVID-19 across Africa, but to strengthen our current health systems.

Of course, all information systems and digital tools must comply with an individual country's norms and standards. There are pockets of excellence in some areas of Africa, but in others these systems and tools do not function optimally. National or sub-national digital health strategies have been developed and adopted by many countries.

These are designed to help the health sector to manage health data, its generation, compilation, analysis, synthesis and use. It is a means by which the use of information contributes to the efficient running of the health system and effective rendering of health services. The information that is organised and managed includes patients' electronic medical records, health management systems at different levels of care, health system information tools crucial for supporting policy-making, and capabilities to support providers of services and routine data collection. These, too, are in various states of development and maturity, requiring much attention.

Clearly the implementation of these strategies has not been fully achieved by most countries, partly due to capacity and resource constraints coupled with infrastructure and human resource limitations. COVID-19 presents an opportunity to bring about innovations that will help countries leapfrog to more robust digital health systems and upgrade those that are struggling through virtual health services, e-learning programmes and electronic data exchanges. The pandemic therefore offers a window of opportunity to transform health systems through digitisation in the post-recovery phase – and it needs to be maximised.

This digital transformation precipitated by the COVID-19 pandemic will only work if bold steps are taken to disrupt, diffuse and democratise our health systems. We need to engage the entire digital innovation community – including big multinationals, start-ups, researchers, hackers and social entrepreneurs – to bring digital health solutions closer to communities and providers, to support social behaviour change, transform surveillance systems, strengthen our measures to test isolate and treat, create mechanisms that fast-track access to therapeutic interventions, diagnosis and treatment, simplify communications and curtail misinformation. Further to this, we must extend all of these more equitably to the remote areas and communities that need them the most.

This is humanity's first digital pandemic. Let's use that opportunity for global good.

1. John's Hopkins University of Medicine, 29 April 2020.
2. Africa CDC, Outbreak Brief 15: COVID -19 Pandemic, 28 April 2020.
3. Commonwealth Coronavirus COVID-19 Tracker, 2020.
4. Africa CDC JOINT actions to improve health security is an action plan signed between the two agencies to tackle health security.
5. WHO. Atlas of eHealth country profiles: The use of eHealth in support of universal health coverage, 2015.
6. ITU. Measuring digital development: Facts and Figures 2019.

INDUSTRY STANDS TOGETHER

in fight against COVID-19

A lot has happened in our world in just under two months and our lives have shifted dramatically. We have been forced to relook at how we live, work and interact with one another. Some have lost their jobs; others have lost their loved ones. We are, however, encouraged that many have extended a helping hand of support to families and communities affected by COVID-19.

Individuals and businesses alike are working collaboratively and moving swiftly in this regard. The true meaning of leadership lies not in directing but in serving people, and such leadership has indeed emerged.

GEMS

The Government Employees Medical Scheme (GEMS) has allocated around R900 million for the care and treatment of GEMS beneficiaries who contract COVID-19. This will come from the scheme's risk fund to ensure that members' day-to-day benefits or savings are not affected during this difficult time.

MEDSHIELD

Medshield stepped up by embracing telehealth, enabling members to access doctors via remote consultation. These efforts have increased the capacity of

healthcare professionals to consult with more people during a time when contact is not ideal. In efforts to assist in increasing resources for COVID-19 testing, Medshield also donated a Hyundai panel van and just over R500 000 to the National Institute for Communicable Diseases (NICD). Furthermore, its principal officer took a 30% salary cut in an effort to enable the organisation to shoulder the financial burden imposed by COVID-19.

UNIVERSAL HEALTH

Universal Health established the Universal Foundation, a not-for-profit entity to raise funds to help those in need during the pandemic. Universal has engaged with the national Department of Health to establish emergency high care and ICU field hospitals to increase the number of specialised hospital beds to care for very ill COVID-19 patients.

COMPCARE MEDICAL SCHEME

CompCare Medical Scheme is among the schemes that paid for testing even before COVID-19 was declared a prescribed minimum benefit. The scheme has been paying for member tests to help shoulder the financial burden of COVID-19 and, in turn, encourage an overall increase in testing.

BONITAS MEDICAL SCHEME

Bonitas Medical Scheme extended a helping hand by providing free virtual medical consultations to all South Africans through a virtual care app. Available to both members and non-members, the services include medical advice on all issues relating to COVID-19 and other medical and healthcare issues, the issuing of prescriptions and, where necessary, free delivery of chronic medication. Bonitas also set up a self-help platform on WhatsApp and a COVID-19 hub on their website to ensure that all South Africans continue to receive up-to-date information about COVID-19.

MEDSCHEME

Medscheme, which administers 17 medical schemes, negotiated lower rates with pathology laboratories for better testing of COVID-19. Medscheme also offered members the option to buy down, and the opportunity to pay contributions from medical savings accounts. Medscheme was also able to relax its suspension rules

to accommodate members struggling to meet contribution deadlines. Medscheme has also developed a rapid response unit to provide quicker turnaround support to medical schemes.

MEDIMED

Medimed offered financial support to members by reducing premiums by a record 50% during these financially difficult times.

POLMED

Polmed, in partnership with Gift of the Givers, assisted in the free screening of 550 policemen at the FirstCare screening station.

BPOMAS

To ensure that people are informed and have first-hand expert information on COVID-19, the Botswana Public Officers' Medical Aid Scheme started running a series of Facebook wellness programmes every Tuesday and Thursday at 09h00.

BCIMA

BCIMA, the Building and Construction Industry Medical Aid Fund, continues to support its members in the building and construction sector by offering premier health benefits, which are vital during the crisis.

RENAISSANCE HEALTH MEDICAL AID

Across the region, Renaissance Health Medical Aid Fund, a leader in private health funding in Namibia, contributed N$500 000 for the production of PPE to help in the fight against COVID-19.

THE COMPENSATION FUND

The Compensation Fund will compensate affected workers through its existing illness and reduced work time benefits.

EOH

EOH released Sikhona, a corporate crisis-management app to support corporates with high performance strategies that leverage technology to support people on how to solve COVID-19 challenges.

ENGEN MEDICAL BENEFIT FUND

Engen Medical Benefit Fund set up an online doctor consultation platform to allow off-site medical consultations, risk screening and access to reliable information for its members.

CIMAS MEDICAL AID

Cimas Medical Aid supported the Confederation of Zimbabwe Industries in its coordination of the private sector response to COVID-19, and plays a critical role in ensuring that all support centres receive the equipment needed to function. Cimas has contributed ZWL 3 750 000 to the fight against COVID-19 in the country, channelling funds to various facilities.

Cimas is also one of the schemes driving telemedicine in Zimbabwe through its Medic Express platform, which provides quick delivery of medicines to its members' doorsteps. Additionally, Cimas has developed an online symptom checker that allows doctors to help members to check COVID-19-related symptoms.

FIRST MUTUAL HEALTH

First Mutual Health donated $750 000 towards food packs to support families in distress in Zimbabwe.

NEDGROUP MEDICAL AID SCHEME

The Nedgroup Medical Aid Scheme (NMAS) implemented a number of operatio-nal efficiency strategies to increase TTO (to take out) limit, lift certain co-payments and reduce the need for certain motivations and documents for admission.

NMAS also introduced a number of out-of-hospital benefits, e.g. providing care plans that include consultation, pathology and radiology services for COVID-19. The scheme continues to provide support focused on mental health and assessing the overall wellness of members, providing counselling where necessary. NMAS has also relaxed credit control for pensioners to provide financial relief for the elderly.

PULA MEDICAL AID

PULA Medical Aid is utilising its VAT fund to help members. The fund was extended to cover influenza vaccines for members registered on the chronic disease programme and those aged 60 and above. The fund has been critical in allowing the dispensing of three months' chronic medication, including that for HIV, for members registered on the chronic disease programme. The scheme's pensioner membership receives 100% cover for COVID-19, and the 10% member co-payment

on COVID-19 hospital admissions and diagnostics have been waived.

IMPERIAL MOTUS MED

Imperial Motus Med was one of the first medical schemes to introduce a new influenza virus vaccine to provide additional protection to high-risk beneficiaries over the age of 65, and to beneficiaries who have been diagnosed with cancer, asthma, chronic obstructive pulmonary disease, cardiac failure and HIV. The vaccine is one of a kind in supporting and strengthening the immune system and is being used to help patients fight COVID-19.

BONVIE MEDICAL AID SCHEME

Bonvie Medical Aid Scheme developed an app for its members to submit COVID-19 claims; this will ensure quicker turnaround in the authorising and processing thereof.

THE FOSCHINI GROUP (TFG)

The Foschini Group donated 10 000 t-shirts to workers who were deployed by the Department of Health to travel through communities across South Africa to test citizens for Covid-19. All 10 000 t-shirts are 'Proudly SA' manufactured locally by TFG's Prestige Caledon factory. TSG continues in efforts to help those in the frontline fighting this pandemic.

SWAZILAND MEDICAL AID FUND

Swaziland Medical Aid Fund donated R200 000 to the eSwatini Resource Mobilisation Committee for the purchase of PPE.

It is encouraging to see how BHF members have stepped up to tackle the challenges presented by COVID-19.

HOSMED MEDICAL AID SCHEME

Hosmed Medical Aid Scheme developed a COVID-19 toolbox.

MH HEALTH AND MOMENTUM METROPOLITAN GROUP

The MH Health and Momentum Metropolitan Group contributed about R5 million to the Solidarity Fund, while the group's CSI team committed over R4 million to support the vulnerable communities affected by COVID-19. The scheme has made R26 million in no-claims safety bonus available to support members during these times.

Working in partnership with Gift of the Givers, the group has established a drive-through testing facility at its head office in Bellville, Cape Town. It is also providing pro bono administration services to the Western Cape Department of Health with regard to its contracting of private hospitals for COVID-19 patients initiatives.

Momentum is also using telemedicine to deliver innovative and easy-to-access medical support to increase COVID-19 screening and testing using its Hello Doctor app.

MEDIPOS MEDICAL SCHEME

Medipos Medical Scheme developed a self-help kit to support a quicker turn around in testing and supporting members with self-help.

SUREMED HEALTH

Suremed donated funds to support the Gift of the Givers to mobilise resources in their efforts in the fight against Covid-19.

It is encouraging to see how BHF members have stepped up to tackle the challenges presented by the pandemic. Many have set up hotlines and response centres for a quicker turnaround in response to cases. Several of our members have also applied to allow their members to use accumulated funds to cover their premiums during these difficult times. Some medical schemes have also created new benefits packages, including risk pooling, to cover diagnosis, treatment and hospital care for members, irrespective of benefits.

Moreover, we have seen the industry mobilise and come together to lobby the Health Professions Council of South Africa to lift the telemedicine ban to permit doctors and therapists to use video or phone calls to treat patients. This has been critical in enabling access to healthcare and, within the context of COVID-19, minimising the risk of infection.

We honour all your efforts and encourage you to share all that you are doing with us so that we may continue to speak as one industry voice.

COVID-19 Testing Sites

SITES	PROVINCE	ADDRESS	TEL
Parkhurst Clinic	JHB	Stand 506 C/O 14th & 5th Ave Parkhurst	0117881526/7
Bosmont Clinic	JHB	Stand 1432 C/O Maraisburg & Griffiths Road, Bosmont	0114743413
Rex	JHB	Stand 782, 15 Rex Str, Roodepoort	0117602231
Weltevredenpark	JHB	Stand 2944, 1047 JG Strijdom Road, Weltevreden Park Ext 24	0116753038
Cosmo City	JHB	Cnr South Africa Road & Angola Road Cosmo City	0828575973
Braamfisher	JHB	Multipurpose Centre: Braam Fischer, Phase 2	0828186575
Barney Molokwane	JHB	Stand 2896 Ext 1 Orange farm	0118507519
Eldorado Park Ext 2	JHB	Stand 3319, 101 Arlberg & Witterberg, Eldorado Park Ext 2	0119454203
Thula-Mntwana clinic	JHB	Stand 1947 Kanana park Ext 5	0827434572
Crown Gardens	JHB	Stand 106 Recreation Centre, Crown Gardens	0114332351
South Hills	JHB	Stand 618 C/O Geneva & Estantia Str, South Hills	0116231297
Shanty Clinic	JHB	1000 Armitage Road, Orlando West	0119392015
Jabavu	JHB	3123 Thumahole Street, white city jabavu, Soweto	0119844014
Michael Maponya	JHB	1479 Nqaya Str, Pimville Zone 1	0119332503
Diepkloof Clinic	JHB	Erf No. 15643; 3790 Marthinus smuts drive diepkloof zone 3	0119851104
Halfway House	JHB	Erf 18&19 Market street & moritz, halfway house	0118053112
Diepsloot Clinic	JHB	Erf 5355, JB Marks Drive Diepsloot Ext 7	0114645396
Bophelong Clinic	JHB	Erf 3700 Freedom Drive Ivory Park Ext 6	0112611212
Charlotte Maxeke Academic Hospital	JHB		0114898853
Tshwane Academic Hospital	JHB		0123192257
Dr George Mukhari Hospital	JHB		0125214227
Alberton IPS	JHB	68 Voortrekker rd, New Redruth Alberton	
Netcare Mulbarton	JHB	Room 206 Mulbarton Medical Centre, 27 True N Rd Hospital	
Lenmed Lenasia	JHB	Lenmed in Hospital, Lenasia South	
Daxina Medical Centre	JHB		
Krugersdorp Lab	JHB	Outpatient Depot, 1 Boshoff Street, Krugersdorp	
Soweto Healthcare Hub	JHB		
Birchleigh Depot	JHB	7 Leo Street	
Kempton Square	JHB	Kempton Square shopping centre Shop 61	
Leicester Medical Mews	JHB	Suite 8 Leicester Medical Mews, 7 Leicester Road Bedfordview Germiston	
Houghton Hotel	JHB	53 2nd Ave, Houghton Estate	
Cheltondale	JHB	62 Orchard Road, Cheltondale	
Lancet Corner Richmond	JHB	Cnr Stanley & Menton Rd, Richmond Auckland Park	
Rosebank Lab	JHB	3rd Floor, 8 Sturdee Ave, Rosebank	
Morningside	JHB	173 Rivonia Rd, Morningside, Sandton	

USEFUL RESOURCES

SITES	PROVINCE	ADDRESS	TEL
Groote Schuur Academic Hospital	CT		0214045201
Tygerberg Academic Hospital	CT		0219389354
Belville	CT	2 Heide Street, Bloemhof	
Brackenfell	CT	Brackenfell Medical Centre, Cnr Brackenfell & Old Paarl Road	
Cape Town CBD	CT	Cnr Longmarket & Parliament Str	
Century City	CT	Smartsurv House, Century City	
Durbanville	CT	15 paul Kruger Street Drbanville	
Kuils River	CT	shop 9 De Kuilen Shopping Centre Carinus Street	
Belville West	CT	7c Solway Street, Belville West A	
Pinelands	CT	91 Jan Smuts Dr, Pinelands	
Rondebosch	CT	Rondebosch Medical Centre, 95 Klipfontein Rd	
Simonstown	CT	1st Floor Room 4 HarbourBay Medical Centre	
Stellenbosch	CT	Trumali House, Trumali Street, Harringtons Place	
Somerset West	CT	Arun Place Block 6 Unit F, Cherrywood Gardens, Sir Lowry's Pass	
Stellenbosch Oewerpark	CT	Stellenbosch Oewerpark Suite 12A Rokewood Road, Die Boord	
Inkosi Albert Luthuli Central Hospital	KZN	0312402794	
Lenmed La Verna Private Hospital	KZN	1 Convent Road, Ladysmith	
Mediclinic Newcastle Private Hospital	KZN	78 Bird St, Newcastle Central	
Life Empangeni Garden Clinic	KZN	50 Biyela St, Empangeni Central	
Busamed Gateway Private Hospital	KZN	Busamed Gateway private hospital, 36-38 Aurora Dr, Umhlanga Rocks	
Berea	KZN	1st Floor Mayet Medical Centre, 482 Randles Road, Sydenham	
Ahmed Al-Khadi Private Hospital	KZN	490 jan Smuts Hwy, Mayville	
NHLS Port Elizabeth Virology	PE		0413956120
Universitas Hospital	Free State		0514052834
Mediclinic Bloemfontein	Free State	Room G07, Mediclinic Bloemfontein, Kellner Str, Westdene	
Kimberley	Free State	112 mac Dougall St, El Toro Park	
Welkom	Free State	RH Matjhabeng, Power Rd, Reitzpark	
Polokwane	Limpopo	44A Grobler Street	
Tzaneen	Limpopo	71 Wolksberg Road, Ivory Tusk Lodge	
Thouyandou	Limpopo	Corner Mpehephu & Mvusuludzo near Cash Build	
Phalaborwa	Limpopo	Clinix Private Hospital No 86 Grosvenor Street	

6 NOVEMBER 1951 - 11 MAY 2020

REMEMBERING Dr. Clarence Mini

The Board of Healthcare Funders is deeply saddened by the recent passing of Dr Clarence Mini from COVID-19. An industry legend, Dr Mini played a significant role at foundation level of at the BHF. After the departure of the late former MD, Dr Humphrey Zokufa, Dr Mini supported and led the team while the BHF was looking for a replacement.

He was deeply rooted in the organisation at a time when the BHF required leadership internally, when the organisation was going through a period of political turmoil and was at risk of disintegrating.

He provided the leadership that was needed and put the interests of the organisation first. His views on UHC were far ahead of their time, and he saw its value long before many understood the concept. We are here today because of his resilience and the efforts he made to keep the organisation standing. He was a strong and decisive yet compassionate and humble leader, who made a difference to the institutions and people with whom he made contact. He challenged leaders and policy-makers to look closely at the realities of the people and the communities who benefit from the healthcare sector.

He volunteered his time to support efforts to develop the public health sector, sharing best practices and providing honest insights into its realities. He was not afraid to go into hospitals in townships and remote areas to gain an understanding of the realities faced by healthcare professionals and community members. He was pivotal in the development of young professionals in the sector, to whom he served as a mentor.

He was passionate about providing support to enable people to develop, organisations to grow, and institutions to become efficient. He did not tolerate inefficiency, always spoke the truth and challenged the status quo. As part of the Value Input Accreditation Committee, where he served as a volunteer reporting to the MEC of Health on areas that need improvement in public healthcare facilities and quality assurance standards, he was genuinely concerned about the welfare of others.

We are grateful to his family for sharing him with the industry, for understanding his passion and allowing him to follow his purpose.

We have lost a leader and a legend, a friend and a compassionate patriot. Farewell Dr Mini, you will be deeply missed by all of us at the BHF.

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Tyrwhitt Avenue, Rosebank, 2196

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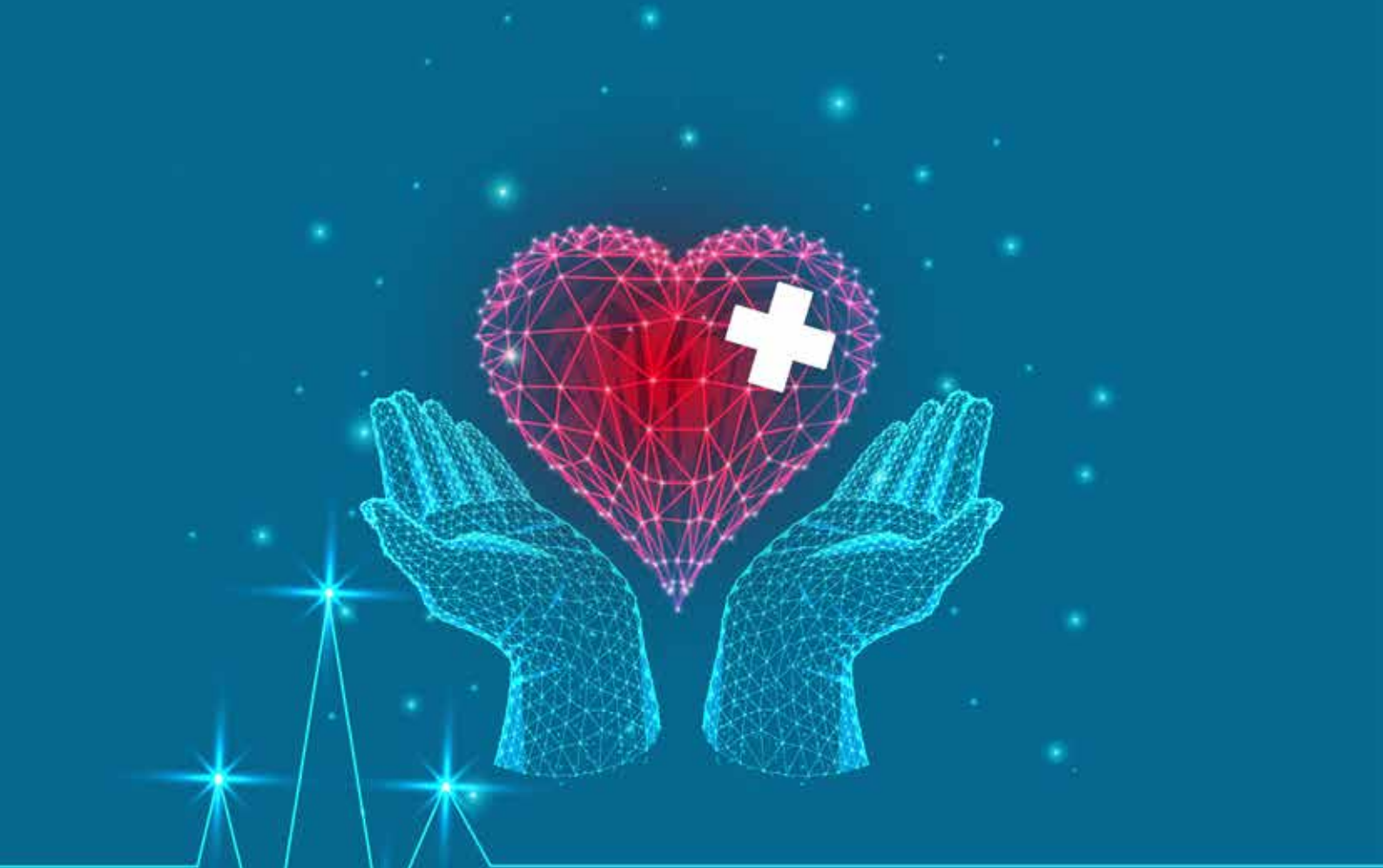
B·H·F

BOARD OF HEALTHCARE FUNDERS



THANK YOU TO ALL THE FRONTLINE WORKERS

B·H·F

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