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Newsletter

The Future of Pharma in South Africa: Between Crisis and Cure



South Africa's Pharmaceutical Crossroads: A Strategic Outlook for the New Era

South Africa's pharmaceutical sector is a complex and contradictory market which is regarded as the most advanced and sophisticated in sub-Saharan Africa.

It also operates within a domestic economy grappling with significant volatility and structural constraints.¹ This report, tailored for a professional audience, provides an overview of how the broader economic environment is shaping the industry and highlights the key factors influencing production, access, investment, and growth.

The central thesis is that the market is facing profound transformation, moving from a long-standing dual-tiered system to a single envisaged public-health-centric model. The confluence of macroeconomic headwinds and radical policy shifts, most notably the National Health Insurance (NHI) Act and parallel intellectual property (IP) reforms, is creating both a high-stakes environment and significant opportunities for agile players.

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QualiCare

WORCESTER OPEN DAY EVENT 2025

SAVE THE DATE

Following Topics and More:

Dyslipidemia: Managing LDL in high-risk patients with combination therapy.

NHI update.

Dermatology for the General Practitioner.

OHSC Update.

Diabetes – Latest trends for the General Practitioner.

Medical Inspectors, an update.

Intelligent yet Ethical Banking for medical practitioners and more.



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Date: 18 October 2025

Venue: Worcester Faculty of Medicine and Health Sciences, Stellenbosch University, Campus, 1 Durban Street



THE MACROECONOMIC HEADWINDS: A FOUNDATION OF INSTABILITY

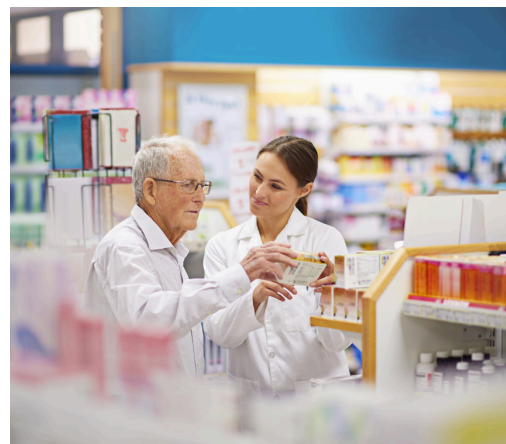
The South African pharmaceutical sector operates against a backdrop of challenging macroeconomic conditions that directly influence its operational viability and growth.

SUBDUED ECONOMIC GROWTH:

The national economy has shown a pattern of sluggish performance, with real gross domestic product (GDP) expanding by a marginal 0.1% in the first quarter of 2025.² While a surge in the agriculture sector narrowly averted a contraction, key industrial sectors like manufacturing and mining were the largest negative contributors to growth.² This tepid growth creates fiscal limitations for the government, constraining its ability to fund public health initiatives.⁴ In fact, while public health spending is projected to increase at an average annual rate of 4.3% from 2023/24 to 2026/27, this is partially offset by Cabinet-approved reductions, resulting in a net overall decrease over the medium term.⁵

CURRENCY VOLATILITY AND INFLATIONARY PRESSURES:

For an industry that relies almost entirely on imports, currency volatility presents an acute threat to the cost base.⁶ Approximately 98% of the country's Active Pharmaceutical Ingredients (APIs) are imported, costing the country around R15 billion annually.⁶ APIs account for 60-80% of a drug's production cost, meaning any weakening of the volatile South African Rand (ZAR), directly and disproportionately increases production costs for local manufacturers.⁷ The Single Exit Price (SEP) mechanism, which regulates medicine prices in the private sector, lacks the flexibility to compensate for sudden exchange rate shifts, leading to a steady erosion of profit margins.⁹ This regulatory friction, coupled with high upfront capital costs, creates a powerful disincentive for companies to invest in local production facilities.¹⁰





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THE POLICY TSUNAMI: A SYSTEMIC OVERHAUL

The pharmaceutical industry is not only shaped by economic forces but is also undergoing a radical transformation driven by a series of landmark policy changes:

THE NATIONAL HEALTH INSURANCE (NHI) ACT:

The presidential assent of the NHI Act in May 2024, subject to the outcome of 9 current court applications against the NHI, could signal a monumental shift toward a single-payer system.¹¹ The Act, which aims to provide universal healthcare based on need rather than income, is designed to dismantle the long-standing dual healthcare system.¹² Under the current model, the high-margin, low-volume private sector, which serves a minority of the population, generates the profits that enable companies to compete in the low-cost public tender system.¹ By stating that medical aids will only be allowed to cover “top-up services,” the NHI Act is intentionally engineered to dismantle this cross-subsidization model.¹⁴ This will force a fundamental re-evaluation of pricing and market access strategies, shifting the industry from a two-tiered market to a single, high-volume, low-cost system.¹



INTELLECTUAL PROPERTY (IP) REFORM:

In parallel with the NHI, the government is pursuing an overhaul of its IP laws, aiming to limit the number of pharmaceutical patents and relax restrictions on generic drugs.¹⁵ The government argues this will cause drug prices to “fall drastically” and improve access to medicines for a population with a “massive disease burden”.¹⁵ The pharmaceutical industry, however, has reacted with alarm. Innovative Medicines South Africa (IMSA) has called the reforms “discriminatory, unfair and unconstitutional,” warning of a “loss of confidence in and damage to the South African economy”.¹⁵ The industry’s concern is that, as the “hub for the pharmaceutical industry in Africa,” a loss of strong IP protection in South Africa could set a dangerous precedent for other developing nations.¹⁵

THE NEW FRONTIER: PRODUCTION, ACCESS, AND GROWTH:

The industry’s core functions of production, patient access, and market dynamics are being reshaped by the interplay of economic and policy forces.

PRODUCTION AND SUPPLY CHAIN VULNERABILITIES:

While South Africa has a well-developed formulating industry, with 60-70% of finished pharmaceutical products produced locally, this capacity is undermined by the almost complete reliance on imported APIs.⁶ This reliance creates a significant trade deficit and exposes the local industry to global supply chain shocks, as was demonstrated during the COVID-19 pandemic when export bans from major API suppliers led to shortages.⁷ While local production could be 5-15% cheaper by eliminating tariffs and shipping costs, high upfront capital investment and policy hurdles have thus far been a deterrent.¹⁶

MARKET SEGMENTATION AND PATIENT ACCESS:

The South African market is a study in a "volume vs. value" paradox. Generics, driven by government policies promoting affordability, are the dominant force by volume, accounting for over 60% of the market.¹ The generic pharmaceuticals contract manufacturing market is projected to grow at a robust CAGR(Compound Annual Growth Rate) of 9.3% from 2025 to 2030, fuelled by the government's push for affordability.⁸ In contrast, branded drugs still command a dominant 67.2% of the market by revenue, driven almost entirely by the private sector's preference for originator brands and the high price of innovative therapies.¹ The NHI is designed to address this profound inequity by making access to a comprehensive set of universal benefits.¹¹

GROWTH PROJECTIONS:

Despite the challenges, the overall pharmaceutical market is projected to grow at a CAGR of 5.3% from 2025 to 2030, reaching US\$10.74 billion by the end of the period.¹⁷ The most lucrative and fastest-growing segment is biologics and biosimilars, with a projected CAGR of 12.3% from 2024 to 2032.¹ This dual growth trajectory indicates that successful pharmaceutical companies in South Africa will need to manage a diversified portfolio, catering to both the high-volume demand for generics and the high-value demand for innovative biologics.





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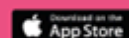
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THE PATH FORWARD: STRATEGIC IMPERATIVES

The convergence of economic instability and policy-driven disruption creates a new environment for strategic decision-making. The high-margin private market is a declining strategic focus. Future investment may well be driven by the potential to become a long-term, high-volume supplier to the NHI fund.¹ The government's initiatives, such as tax breaks for companies investing in local production and grants for R&D, provide incentives for this new investment paradigm.¹⁸

Furthermore, technology is potentially emerging as a critical enabler for the success of a future NHI's universal access mandate. In a system where demand consistently outweighs capacity, AI-powered tools are being leveraged to improve diagnostics, reduce administrative burdens, and extend care to underserved communities.¹⁹ Examples include the use of AI for retinal screening for diabetic retinopathy and computer-aided detection systems for tuberculosis (TB) diagnostics in mobile X-ray vans.¹⁹ For pharmaceutical and medical technology firms, this push for digitalization represents a new and growing market segment and an opportunity to align with future long-term health objectives.²⁰

CONCLUSION :

South Africa's pharmaceutical industry stands at a crossroads. The economic headwinds of sluggish growth and currency volatility, combined with the systemic shock of the NHI Act and its possible future full implementation, are forcing a fundamental re-evaluation of business models. The industry's future success will be defined by its ability to navigate this new landscape, pivot to a high-volume, low-cost model, and leverage technology to address the country's profound health needs. For those companies which can adapt, South Africa remains a strategic gateway to the broader African market, presenting opportunities for growth, innovation, and long-term impact.¹

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References: 1. Current DoH price file. 2. Lawate P. et al; Effectiveness of Rabeprazole and Other Proton Pump Inhibitors in Managing GERD with Varying Severity: A Retrospective, Real-world EMR-based Study (POWER GERD Study); Journal of the Association of Physicians of India (2023); 10.59556/japi.71.0366.
HCR: Macleods Pharmaceuticals SA (Pty) Ltd. Ground Floor, Office Block 1, Bassonia Estate Office Park (East), 1 Cussonia Drive, Bassonia Rock, Ext 12, Alberton, Gauteng, South Africa. 2061. Tel: +27 11 682 1169



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**TO: ALL INFORMATION OFFICERS, HEADS OF PRIVATE BODIES AND
DEPUTY INFORMATION OFFICERS**

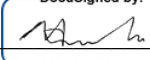
Dear All

**NON-COMPLIANCE WITH REGULATION 7.1 OF REGULATIONS RELATING TO
THE PROMOTION OF ACCESS TO INFORMATION, 2021**

1. The Information Regulator ("Regulator") is empowered, in terms of section 77H (1) of the Promotion of Access to Information Act No. 2 of 2000 (PAIA), to conduct compliance assessments on its own initiative or upon receipt of a request. The purpose would be to determine whether a public or private body complies with the provisions of PAIA as far as its policies and implementation procedures are concerned.
2. The Regulator is also enjoined by section 77C (1) (a) of PAIA to investigate complaints related to access to information and lodged in terms of section 77A of PAIA. In the execution of the investigative mandate, the Regulator has noted with concern the continued use of the repealed PAIA request **Form A** by private and public bodies, notwithstanding a notice issued by the Regulator in 2021 communicating the new PAIA forms.
3. The use of incorrect PAIA forms amounts to non-compliance with regulation 7.1 of the Regulations relating to the Promotion of Access to Information, 2021 (Regulations), which provides that ***"a request for access to a record contemplated in section 18(1) or 53(1) of the Act, must be made on a form that corresponds substantially with Form 2 of Annexure A to the Regulations, to the Information Officer."***
4. This continued non-compliance is hampering access to information as well as the Regulator's mandate to investigate complaints lodged. Consequently, all Information Officers / Heads of Private Bodies and Deputy Information Officers are hereby directed to ensure that the prescribed **Form 2** is utilised when processing requests for access to information and provided to requesters as and when requested. The prescribed form can be accessed by using the following hyperlink: [InfoRegSA-PAIA-Form02-Reg7.pdf](#).

5. For any general enquiries relating to compliance with the relevant PAIA regulations, kindly contact the Executive responsible for Promotion of Access to Information, Adv. Makhwedi Makgopa-Madisa at MMakgopa-Madisa@infoRegulator.org.za.

Yours faithfully,

DocuSigned by:

886A33C70AA944F...
Mr Mosalanyane Mosala
CHIEFEXECUTIVEOFFICER
Date 28-Aug-2025 | 06:33 SAST

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FORM 2

REQUEST FOR ACCESS TO RECORD

[Regulation 7]

NOTE:

1. Proof of identity must be attached by the requester.
2. If requests made on behalf of another person, proof of such authorisation, must be attached to this form.

TO: The Information Officer

(Address)

E-mail address:

--

Fax number:

--

Mark with an "X"

☐

Request is made in my own name

☐

Request is made on behalf of another person.

PERSONAL INFORMATION				
Full Names				
Identity Number				
Capacity in which request is made (when made on behalf of another person)				
Postal Address				
Street Address				
E-mail Address				
Contact Numbers	Tel. (B):		Facsimile: <table border="1"><tr><td></td></tr></table>	
Cellular:				
Full names of person on whose behalf request is made (if applicable):				
Identity Number				
Postal Address				

Street Address			
E-mail Address			
Contact Numbers	Tel. (B)		Facsimile
	Cellular		
<p align="center">PARTICULARS OF RECORD REQUESTED</p> <p><i>Provide full particulars of the record to which access is requested, including the reference number if that is known to you, to enable the record to be located. (If the provided space is inadequate, please continue on a separate page and attach it to this form. All additional pages must be signed.)</i></p>			
Description of record or relevant part of the record:			
Reference number, if available			
Any further particulars of record			
<p align="center">TYPE OF RECORD (Mark the applicable box with an "X")</p>			
Record is in written or printed form			
Record comprises virtual images (this includes photographs, slides, video recordings, computer-generated images, sketches, etc)			
Record consists of recorded words or information which can be reproduced in sound			
Record is held on a computer or in an electronic, or machine-readable form			

FORM OF ACCESS <i>(Mark the applicable box with an "X")</i>	
Printed copy of record <i>(including copies of any virtual images, transcriptions and information held on computer or in an electronic or machine-readable form)</i>	
Written or printed transcription of virtual images <i>(this includes photographs, slides, video recordings, computer-generated images, sketches, etc)</i>	
Transcription of soundtrack <i>(written or printed document)</i>	
Copy of record on flash drive <i>(including virtual images and soundtracks)</i>	
Copy of record on compact disc drive <i>(including virtual images and soundtracks)</i>	
Copy of record saved on cloud storage server	

MANNER OF ACCESS <i>(Mark the applicable box with an "X")</i>	
Personal inspection of record at registered address of public/private body <i>(including listening to recorded words, information which can be reproduced in sound, or information held on computer or in an electronic or machine-readable form)</i>	
Postal services to postal address	
Postal services to street address	
Courier service to street address	
Facsimile of information in written or printed format <i>(including transcriptions)</i>	
E-mail of information <i>(including soundtracks if possible)</i>	
Cloud share/file transfer	
Preferred language <i>(Note that if the record is not available in the language you prefer, access may be granted in the language in which the record is available)</i>	

PARTICULARS OF RIGHT TO BE EXERCISED OR PROTECTED <i>If the provided space is inadequate, please continue on a separate page and attach it to this Form. The requester must sign all the additional pages.</i>	
Indicate which right is to be exercised or protected	

Explain why the record requested is required for the exercise or protection of the aforementioned right:	

FEES	
a)	A request fee must be paid before the request will be considered.
b)	You will be notified of the amount of the access fee to be paid.
c)	The fee payable for access to a record depends on the form in which access is required and the reasonable time required to search for and prepare a record.
d)	If you qualify for exemption of the payment of any fee, please state the reason for exemption
Reason	

You will be notified in writing whether your request has been approved or denied and if approved the costs relating to your request, if any. Please indicate your preferred manner of correspondence:

Postal address	Facsimile	Electronic communication (Please specify)

Signed at _____ this _____ day of _____ 20 _____

--

Signature of Requester / person on whose behalf request is made

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Reference number:	
Request received by: (State Rank, Name And Surname of Information Officer)	
Date received:	
Access fees:	
Deposit (if any):	

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Signature of Information Officer



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05 September 2025

Dear Valued Healthcare Provider,

We want to inform you that Sizwe Hosmed Medical Scheme has been placed under Provisional Curatorship by the Gauteng High Court, effective 04 September 2025, after the successful application by the Council for Medical Schemes (CMS).

What does provisional curatorship mean? Provisional Curatorship is a temporary regulatory measure used by the CMS when it believes it is necessary to intervene and strengthen the management and governance of a medical scheme. A curator is appointed by the High Court to oversee and guide the Scheme's operations temporarily

– in this instance, Ms Lebogang Grace Mpakati is the appointed Provisional Curator.

As a result of this process, the Board of Trustees has been dissolved. Responsibilities of the

Provisional Curator:

- The curator oversees the day-to-day running of the Scheme and ensures operations continue as normal, with no disruption to benefits.
 - Ensures that the Scheme complies with regulations and best practices.
 - Reviews governance and other structures to ensure they are strengthened.
- Act in the best interest of members

Why was the Scheme placed under Provisional Curatorship? The Scheme was placed under provisional curatorship to address ongoing solvency concerns, non-regulatory and non-compliance.

This decision has been taken with your best interests at heart, ensuring that the Scheme continues to operate in a manner that is sustainable, transparent, and accountable.

We want to reassure you that your benefits and claims are not affected. All business operations, including authorisations, claims processing, and member services, are continuing as normal. We remain fully committed to ensuring uninterrupted service.

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We're still here, still caring for you. Sizwe Hosmed remains committed to serving you with the highest standard of care. You can expect regular and transparent updates from us as we progress through this process, and we will keep you informed of all important developments.

Sizwe Hosmed urges you to continue serving our members as you have in the past and honouring agreements that are in place. You can expect regular and transparent updates from us as we progress through this process, and we will keep you informed of all important developments.

Thank you for your trust and continued support. Yours sincerely,


Ms Lebogang Grace Mpakati

Provisional Curator

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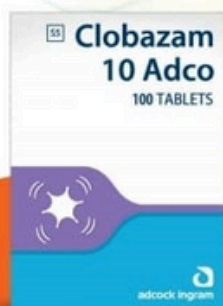
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References: 1. CLOBAZAM ADCO 10 & 20 mg tablets Professional Information, 27 June 2023. 2. Faulkner MA. Comprehensive overview: efficacy, tolerability, and cost-effectiveness of clobazam in Lennox-Gastaut syndrome. Ther and Clin Risk Manage 2015;11:905-914. 3. Generics dictionary. http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=CLOBAZAM (Accessed: 03 October 2023).

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

☐ CLOBAZAM 10 ADCO. Each tablet contains 10 mg of clobazam. Reg. No.: 55/2.6/0546 ☐ CLOBAZAM 20 ADCO. Each tablet contains 20 mg of clobazam. Reg. No.: 55/2.6/0547

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QualiCare **LODGES TWO FORMAL COMPLAINTS WITH THE HPCSA OVER THEIR DELAYS IN PROCESSING CPD POINTS**

CPC/Qualicare IPA has formally lodged a complaint against the Health Professions Council of South Africa (HPCSA) regarding ongoing delays and inconsistencies in the processing of Continuing Professional Development (CPD) points for medical practitioners.

The complaint, submitted by Dr. Tony Behrman, CEO of CPC/Qualicare, outlines serious concerns over the failure of the HPCSA CPD department to accurately credit CPD points for educational activities hosted by CPC/Qualicare over the past year. These activities were fully accredited by the University of Stellenbosch and supported by complete attendance records and accreditation documentation.

“Only some of the doctors who attended our educational sessions have been credited with the correct points, others not at all,” said Dr. Behrman. **“This has caused unnecessary distress among practitioners who are now at risk of non-compliance due to administrative delays.”**

Despite multiple submissions and follow-ups, the issue remained unresolved for weeks. The initial complaint was sent on **26 June 2025**, and a formal reply from the HPCSA was only received on **25 August 2025**, nearly two months later.

In the delayed response, *********, Head of Division: Professional Practice at HPCSA, acknowledged the backlog and confirmed that all pending submissions had been cleared. He also noted that practitioner suspensions were postponed accommodating administrative challenges and that system improvements were underway.

While CPC/Qualicare appreciates the eventual resolution, the extended waiting period for a formal reply has raised concerns about the responsiveness and efficiency of the CPD department.

“We urge the HPCSA to improve its communication and processing systems to ensure that practitioners are not unfairly penalized due to internal delays,” added Dr. Behrman.

CPC/Qualicare IPA Lodges Formal Complaint Against HPCSAcontinue to page 22

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The email communication below:

CPC/Qualicare

Sent: Thursday, June 26, 2025 12:46 PM

Subject: *Formal complaint against the HPCSA CPD department on behalf of the CPC/Qualicare IPA.*

Dear ****,

It is with regret that I again register my extreme concern at the continuing failure of posting up to date CPD points pertaining to CPD accredited lectures which my IPA, CPC/Qualicare, has hosted during the past 12 months.

All of the lectures and related reading were:

- fully accredited by the University of Stellenbosch,
- all of the prescribed attendance lists show the doctors signing in and signing out,
- the accreditation numbers approved by Stellenbosch university,
- our submission to the HPCSA CPD department as well as to the Stellenbosch University accreditation authorities have been followed to the letter.

Only some of the doctors who attended our educational sessions have been credited with the correct points, others not at all!

I require you to look into this matter again with urgency, as these missing CPD points are causing certain doctors great distress with their CPD accreditation.

Their CPD points were honestly earned however they are unable comply with the deadline which HPCSA has imposed on the profession as a result of the apparent slow capturing of the information sent to you and which I again attach to this email as proof all of the electronic records of submissions, resubmissions and re-resubmissions to your department ,however there still appears to be erratic or late processing of rightfully earned CPD points, by the HPCSA CPD division.

CPC/Qualicare IPA Lodges Formal Complaint Against HPCSA.....continue to page 23

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I now require an official response from you as head of this unit, to explain:

- Whether there is a delay in your capturing and if not ,
- What could possibly be the reason why some doctors are receiving their points and others not.

I am raising this now as an official complaint.

NOTE:

You will receive 2 separate emails after this email, each with a zip folder containing previous submissions to the HPCSA.

The files are too large to be sent in a single email, hence the need for separate emails.

Warm regards,
Dr Tony Behrman
CEO CPC/Qualicare T/A CPC Doctors Fund (PTY) LTD
www.docweb.co.za
Director of CPC Holdings (PTY) LTD

HPCSA Response:

Sent: Monday, 25 August 2025 10:15

Subject: *RE:Formal complaint against the HPCSA CPD department on behalf of the CPC/Qualicare IPA.*

Dear Louna,

Thank you for the correspondence. Pardon me for delayed reply.

The HPCSA:

- 1.cleared all the pending submissions and all practitioner's profiles have accordingly been updated. Are you still experiencing undue call volumes on the matter?
- 2.Delayed suspending practitioners to provide for administrative issues experienced; to ensure that no person is disadvantaged.
- 3.Continues to improve the system to infuse effectiveness and efficiencies. Are you experiencing better outcome on matter relating to CPD programme?

Head of Division: Professional Practice
Health Professions Council of South Africa



NEW EVIDENCE ARISES IN CORRUPTION CASE AGAINST DIGITAL VIBES, MKHIZE



The Special Investigating Unit (SIU) says it's confident about the new evidence in its case against Digital Vibes and several other companies and their directors, former Health Minister Dr Zweli Mkhize, and some of his family members.

The SIU has been given the green light by the Special Tribunal to introduce crucial new evidence in the R150 million Digital Vibes scandal, set to be admitted in court. The SIU stressed that the affidavit is critical, warning that without it, important details about how public money was laundered through bogus business dealings could be lost.

Investigators say their findings show the Mkhize family, including Dr. Zweli Mkhize's wife, son and a business associate, personally benefitted from funds meant for COVID-19 and National Health Insurance (NHI) communication contracts. SIU Spokesperson Kaizer Kganyago says, "It was very important for us to introduce their affidavit because we wanted to introduce crucial evidence that shows that certain respondents received money without rendering any service and we feel that if this was not introduced therefore the main case we are dealing with might be decided without the kind of information that was gathered after we start the application to the tribunal that's why it was very important for us to do that."

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FDA APPROVES FIRST-IN-CLASS DRUG FOR FIBROMYALGIA



The FDA has approved cyclobenzaprine hydrochloride sublingual tablets (Tonmya, Tonix Pharmaceuticals), a first-in-class, nonopioid treatment for adults with fibromyalgia, a chronic pain syndrome that affects more than 10 million Americans, roughly 80% of whom are women.

The medication, taken once-daily at bedtime, targets nonrestorative sleep, a root cause of pain, fatigue, and brain fog in fibromyalgia. It's the first new FDA-approved therapy for the treatment of fibromyalgia in over 15 years. Tonmya (formerly TNX-102 SL) is expected to be available in the fourth quarter of this year.

In two double-blind, randomized, placebo-controlled, phase 3 trials (RELIEF and RESILIENT) of nearly 1000 patients with fibromyalgia, sublingual cyclobenzaprine significantly reduced daily pain scores compared to placebo at 14 weeks (the primary endpoint).

In addition, a greater percentage of patients using the medication daily at bedtime experienced a clinically meaningful ($\geq 30\%$) improvement in their pain after 3 months, compared to placebo.

Results of the RESILIENT trial were published online on July 8 in Pain Medicine.

A third phase 3 trial (RALLY) of more than 500 patients with fibromyalgia demonstrated greater but nonsignificant treatment effect with sublingual cyclobenzaprine compared to placebo.

Across all three trials, the medication was generally well tolerated with no serious side effects. The most common adverse events were local administration-site reactions including oral discomfort, dry mouth, and canker sores, as well as fatigue and drowsiness.





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Seniors Neglecting Steps To Protect Heart Health, Study Says



By Dennis Thompson HealthDay Reporter WEDNESDAY, Aug. 20, 2025 (HealthDay News) — Seniors with known heart-related problems aren't doing a very good job taking steps to protect their health, a new study says.

Older folks with high blood pressure, stroke survivors and heart failure patients in the United States all have been neglecting Life's Essential 8 — a checklist of lifestyle factors that can protect heart health, researchers found.



“On average, participants with one cardiovascular disease had a Life’s Essential 8 score 9 points lower than those without cardiovascular disease,” lead researcher James Walker, a medical student at Northwestern University in Chicago, said in a news release.

Life’s Essential 8 recommends that people eat healthy, exercise, avoid smoking, sleep better, lose excess weight, and manage their cholesterol, blood sugar and blood pressure levels, according to the American Heart Association.

For this study, researchers analyzed a sample of more than 3,000 adults 65 and older who participated in the U.S. National Health and Nutrition Examination Survey between 2013 and 2018. The team used people’s responses to estimate their adherence to Life’s Essential 8.

Results showed that people with one or more heart-related health problems had an average score below 60 out of 100, while those without heart problems had an average score of 68. This gap was mainly due to differences in blood pressure control and exercise, Walker said.

“Physical activity and blood pressure scores tended to be very low for people with cardiovascular disease,” Walker said.

What’s more, people’s scores tended to decline with each additional heart-related problem they had, researchers found.

And over time, patients’ adherence to Life’s Essential 8 dropped by:

- 4% among people with high blood pressure.
- 12% among stroke survivors.
- 15% among heart failure patients.
- The results indicate that doctors could be doing more to promote healthy behaviors among people with known heart risks, researchers said.

“Health care professionals and physicians should seek to provide support earlier in life to help our elderly population stay healthier for longer,” Walker said.

The AHA “urges everyone to get their best start at good health by following the elements of Life’s Essential 8 early in life, even as young as childhood,” Dr. Stacey Rosen, volunteer president of the American Heart Association, said in a news release. Rosen was not involved in the study.

“It’s also critical that we recognize that our aging population is quickly growing,” added Rosen, who is senior vice president of women’s health and executive director of the Katz Institute for Women’s Health of Northwell Health in New York City. “The last of the Baby Boomers will reach 65 in the next 5 years, and more people are living longer, even after a heart attack or stroke, thanks, in part, to medical advances and improved diagnosis and treatment.”

“We must identify ways to support these older individuals with information and resources to maintain a healthy lifestyle in every way they can, because good health is important at every age,” Rosen concluded.

The new study appears in the Journal of the American Heart Association.





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ED – erectile dysfunction; EF – erectile function

References: 1. TADALAFIL ADCO Professional Information, October 2022. 2. Gong B, Ma M, Xie W, et al. Direct comparison of tadalafil with sildenafil for the treatment of erectile dysfunction: a systemic review and meta-analysis, *Int Urol Nephrol* 2017;49:1731-1740.

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THE #1 THREAT TO SA WOMEN'S HEALTH IS NOT WHAT YOU THINK

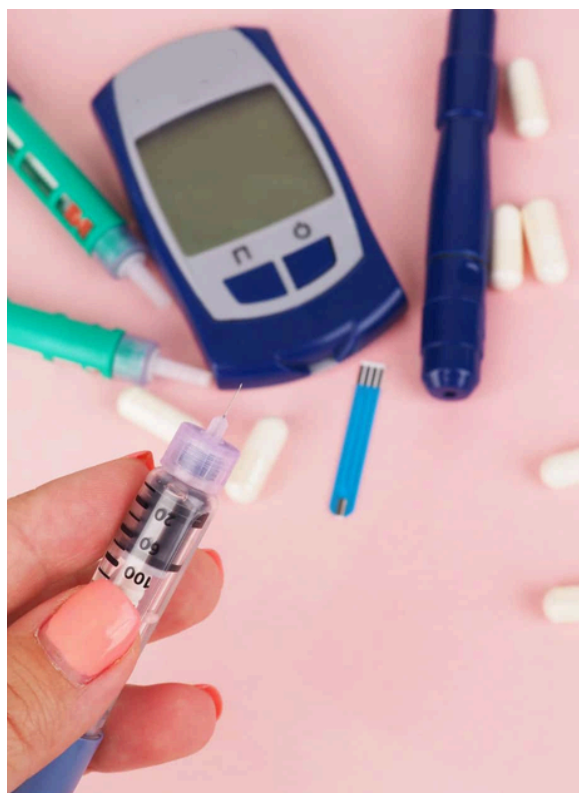
“Women have the power to change the health trajectory of their families and communities. If we support them with the right information and access to care, we can reverse the tide.”

As South Africa marks Women’s Month this August, health experts are warning of a growing but overlooked threat.

Diabetes has become the leading cause of death among South African women – surpassing heart disease, cancer and HIV – and urgent action is needed to reverse the trend.

Despite receiving far less public attention, diabetes has steadily climbed the list of fatal diseases affecting women.

“We’re facing a public health crisis,” says Ingrid Singels, Marketing Manager for Pharma Dynamics’ Scientific Division. “Worldwide, diabetes affects men and women equally, but in South Africa, we see significantly more women living with diabetes than men, and they also face more severe complications. Yet, diabetes remains underdiagnosed and undertreated.”



Understanding the risk factors

The rise in diabetes among South African women is driven by a complex mix of genetic, behavioural and environmental factors. While genetics and family history can increase susceptibility, lifestyle-related factors, such as poor diet, physical inactivity, obesity, smoking and chronic stress play a much larger role in type 2 diabetes.

Other contributors include age, hormonal changes (such as menopause or gestational diabetes), waist circumference and co-existing conditions like high blood pressure and high cholesterol.

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The #1 threat to SA women's health.....continue to page 34



In South Africa, the social determinants of health, namely living in/ close to a city and unemployment, also play a role. Together, these factors set the stage for the development of insulin resistance and long-term blood sugar imbalances.

An epidemic fuelled by obesity

One of the biggest risk factors contributing to the diabetes epidemic among South African women is obesity. According to the South African Demographic and Health Survey (SADHS), nearly 68% of women in the country are either overweight or obese.

Excess body fat, especially around the abdomen, significantly increases the risk of type 2 diabetes by promoting insulin resistance.

“In South Africa, there is a social perception that larger body sizes in women are associated with beauty, health and wealth. While body positivity is important, it’s equally vital to recognise when excess weight poses a genuine risk to one’s health.” says Singels.

The role of socio-economic factors

A woman’s risk of developing diabetes is influenced not only by personal lifestyle choices, but also by her environment and socio-economic circumstances. Research published in BMC Public Health (2023)¹ highlights that women living in urban, low-income settings face significantly higher rates of diabetes.



Contributing factors include limited access to nutritious food, inadequate recreational facilities and poor access to preventative healthcare – creating a cycle that’s difficult to break.

Supporting this, a 2023 study in KwaZulu-Natal published in PLOS ONE² found that women in deprived urban communities bear a disproportionate share of the diabetes burden.

Environmental and structural barriers, like crime, overcrowding, unsafe living conditions and affordable fast food – make healthy living significantly harder. Women also remain the primary caregivers for their families reducing the amount of personal time they have for physical activity.

“These realities show that for many South African women, managing or preventing diabetes isn’t just about making healthier choices, it’s also about addressing the structural and economic challenges that limit those choices in the first place,” highlights Singels.

Communities at higher risk

In South Africa, diabetes- related deaths are statistically higher among Indian and Coloured populations compared to Black or White groups. This is largely due to a mix of genetic predisposition, dietary patterns and socio-economic factors.

Why women suffer more

While diabetes affects both genders, women face unique challenges:

- Hormonal changes during pregnancy and menopause can make blood glucose control more difficult.
- Gestational diabetes, which develops during pregnancy, increases the risk of type 2 diabetes later in life for both mother and child.
- Women are also more likely to suffer from depression, which is linked to poor diabetes self-management and worsened outcomes.

“Many women in our country are caregivers who may tend to put everyone else’s needs before their own. They may ignore warning signs or skip check-ups, which may lead to late diagnoses when complications have already set in.”

Symptoms often go unnoticed

Diabetes symptoms, such as frequent urination, fatigue, blurred vision or increased thirst can be subtle and easily mistaken for stress or ageing. As a result, many people with diabetes in South Africa remain undiagnosed, which could lead to serious health consequences.

“We need widespread public health campaigns tailored to women,” says Singels. “Early screening, especially after 40 or during pregnancy, can save lives.”





What can be done?

There is no cure for diabetes, but lifestyle interventions can prevent or delay its onset:

- Regular exercise (at least 150 minutes per week)
- Weight loss (even a 5–10% reduction can make a difference)
- Balanced and healthy low-GI diet (try these recipes from Cooking from the Heart)
- Routine screening and monitoring

“Women have the power to change the health trajectory of their families and communities. If we support them with the right information and access to care, we can reverse the tide.

“Diabetes doesn’t need to be a death sentence. With early detection, lifestyle changes and ongoing support, it can be managed. The first step is awareness – knowing your risk, recognising the symptoms and getting tested,” encourages Singels.

THE PATHCARE NEWS

THE ABC'S OF MICS: THE VALUE OF MIC RESULTS IN ANTIBIOTIC TREATMENT DECISIONS

As we continue further into the multidrug resistant era, it becomes necessary to develop a deeper understanding of how to perform and interpret antimicrobial susceptibility testing. The clinical microbiology laboratory provides valuable susceptibility data that can guide the selection of antibiotic regimens for patients with infections. When a specific microorganism is cultured, identification of the organism and antibiotic susceptibility testing (AST) is performed. In terms of direct relevance to the management of infectious diseases, AST is arguably the single, most important activity carried out in the microbiology laboratory.

What is an MIC?

The Minimum Inhibitory Concentration (MIC) is an *in vitro* test that determines the lowest concentration of an antibiotic required to inhibit the growth of a specific bacterial strain. A low MIC value (e.g., $<0.12 \mu\text{g/mL}$) indicates that the bacteria are highly susceptible to the antibiotic. In contrast, a high MIC value (e.g., $>32 \mu\text{g/mL}$) suggests that the bacterial strain is resistant, and even high—or potentially toxic—doses of the antibiotic may be ineffective in inhibiting bacterial growth and infection. Generally, the higher the MIC, the more resistant the bacterial strain depending on the antibiotic being tested.

Why is MIC important for patient care?

MICs assist in the selection of antimicrobials to which bacteria or yeast are susceptible and are therefore likely to effectively treat the infection.

How is MIC reported and what do the values mean?

For each bacterial group or fungal species, international standardized cutoff values, referred to as clinical breakpoints, are established for individual agents. These breakpoints facilitate the interpretation of MIC values. This, in turn, enables the laboratory to provide clinically relevant information to guide treatment.

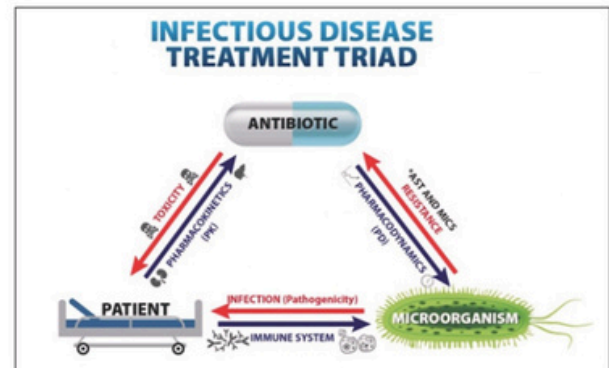
AST reports which include MIC results or breakpoints, will have a numerical value and an interpretive category:

- **S** (Susceptible): there is a high likelihood of therapeutic success using standard dosing regimens
- **I** (Intermediate) or **SDD** (Susceptible Dose Dependent): there is a high likelihood of therapeutic success when exposure to the agent is increased by utilizing a higher dosing regimen or by the agent's physiological concentration at the site of infection
- **R** (Resistant): there is a high likelihood of therapeutic failure even when there is increased exposure (i.e. higher dosing regimen)

While MIC measures the antimicrobial's *in vitro* effectiveness against a microbial strain, it does not fully predict *in vivo* efficacy (i.e., effectiveness in the patient). It is thus important to also consider the drug's pharmacokinetic/pharmacodynamic (PK/PD) properties when selecting an appropriate antibiotic.

Pathogenetic Triad:

1. Figure 1 illustrates the complex interplay between the antibiotic, the patient, and the infecting organism in infectious diseases.



AST and MIC interpretation:

The use of antimicrobials with MIC values that fall within the susceptible category during the treatment of an infection may improve therapeutic efficacy. However, several factors must be considered, including the clinical indication, site of infection, patient characteristics, comorbidities, and the PK/PD properties of the antimicrobial agent.

It is important to note that MIC values are dependent on the specific antibiotic tested as well as the organism for which susceptibility testing is being performed. Importantly, a low MIC value for one antibiotic is not necessarily comparable to a low MIC value for another.

For example, an *E. coli* isolate with a ciprofloxacin MIC of $\leq 0.25 \mu\text{g/mL}$ (susceptible) and an amoxicillin-clavulanate MIC of $\leq 4 \mu\text{g/mL}$ (susceptible) does not imply that ciprofloxacin is the preferred agent. For respiratory tract infections, amoxicillin-clavulanate is generally preferred as it is a first-line agent with a favourable safety profile. In contrast, for complicated urinary tract infections (UTIs), ciprofloxacin may be preferred due to its excellent urinary tract concentrations and prostatic tissue penetration.

Regarding urinary isolates, the MIC for trimethoprim-sulfamethoxazole may appear high at first glance. However, the reported MIC of $20 \mu\text{g/mL}$ reflects a combination of $1 \mu\text{g/mL}$ trimethoprim and $19 \mu\text{g/mL}$ sulfamethoxazole. For *E. coli*, the susceptibility breakpoint for this combination is $\leq 40 \mu\text{g/mL}$ ($2 \mu\text{g/mL}$ trimethoprim and $38 \mu\text{g/mL}$ sulfamethoxazole). Although resistance to trimethoprim-sulfamethoxazole is common, when susceptibility is confirmed, it remains a good option for targeted treatment of infections like UTIs due to its excellent urinary concentration.

THE PATHCARE NEWS

	E.coli
PENICILLINS	
AMOXICILLIN-CLAVULANATE	I 16
AMPICILLIN/AMOXICILLIN	R ≥ 32
PIPERACILLIN-TAZOBACTAM	S ≤ 4
CEPHALOSPORINS	
CEFTAZIDIME	S ≤ 1
CEFUROXIME/CEFTROXIL	I 8
CEFEPIME	S ≤ 1
CEFOTAXIME/CEFTRIAXONE	S ≤ 1
CARBAPENEMS	
DORIPENEM	S
ERTAPENEM	S ≤ 0.5
IMIPENEM	S ≤ 0.25
MEROPENEM	S ≤ 0.25
QUINOLONES	
CIPROFLOXACIN	R ≥ 4
AMINOGLYCOSIDES	
AMIKACIN	S 4
GENTAMICIN	S ≤ 1
TOBRAMYCIN	S ≤ 1
FOSFOMYCIN	
FOSFOMYCIN	S
NITROFURANS	
NITROFURANTOIN	S
SULFA/TRIMETHOPRIM	S ≤ 20

MICs help when antibiotic options are limited:

In critically ill patients in the ICU setting, where the risk of infection with multidrug-resistant organisms (MDROs) is high, it may be necessary to compare the MICs of different agents within the same antimicrobial class to determine the most optimal treatment. For example, in a patient infected with carbapenem-resistant *Klebsiella pneumoniae*, where treatment options are limited, group 2 carbapenems (imipenem, meropenem, and doripenem) may have MICs that fall within the susceptible to intermediate range. In such cases, the carbapenem with the lowest MIC may be considered, often in combination with another active agent from a different class. Additionally, strategies such as dose escalation, prolonged infusion, and increased dosing frequency may be employed to optimise clinical outcomes.

AST and MIC are a valuable antimicrobial stewardship tool:

- AST and MIC reporting helps to guide safe and effective antimicrobial use.
- The 4 Ds of optimal antimicrobial therapy are "the right **D**rug, right **D**ose, **D**e-escalated to pathogen-directed therapy and the right **D**uration of therapy".
- An agent with a narrower spectrum of activity is less likely to select for colonization with MDROs compared to broad-spectrum agents.
- When a broad-spectrum antimicrobial agent is initiated for empiric antibiotic cover, it should be given for the shortest possible duration and de-escalated to the most appropriate directed agent according to PK-PD principles coupled with the culture and susceptibility report.

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Compiled by the PathCare Clinical Microbiology Team

'PATIENTS LITERALLY FROZE TO DEATH': HEALTH OMBUD FINDS FATAL NEGLIGENCE AT NORTHERN CAPE PSYCHIATRIC HOSPITALS

Motsoaledi announced that the national health review committee will visit the two hospitals.

The Health Ombud has released damning findings revealing that poor infrastructure, inadequate equipment, and mismanagement contributed to the deaths of psychiatric patients at two Northern Cape hospitals.

The investigation found that patients literally froze to death due to electricity failures and inadequate care.

Professor Taole Mokoena, the Health Ombud, presented the investigation findings on Wednesday at the Ronnie Mamoepa Press Room in Pretoria.



The probe examined cases involving two patient deaths and inadequate medical care at the Northern Cape Mental Health Hospital in Kimberley and Robert Mangaliso Sobukwe Hospital.

The investigation was initiated following a complaint lodged by Health Minister Dr Aaron Motsoaledi in October 2024 against the Northern Cape Mental Health Hospital.

Two patients die, others critically affected

The investigation established that two patients from the mental hospital died under preventable circumstances.

Seprien Mohoto died on 16 July 2024, at Robert Mangaliso Sobukwe Hospital after being referred from the mental hospital for treatment.

Tshepo Ndimbaza died suddenly at the mental hospital on 3 August 2024.

Three patients were referred from the mental hospital to Robert Sobukwe Hospital in critical condition.

These included John Louw, who was referred on 6 July 6, Mohoto on 13 July, and Petrus de Bruin on 30 July 2024.

According to the Health Ombud, three patients suffered from and died of hypothermia, and one died of multilobe pneumonia.

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'Patients literally froze to death'continue to page 40



Electricity failures lead to deaths

During the critical period, the Northern Cape Mental Hospital experienced severe electricity supply problems due to cable theft and vandalism of the electricity substation serving the hospital and adjacent properties.

“During this time when there was no electricity, patients were freezing to death literally,” Mokoena revealed.

The power failures had catastrophic consequences for patient care. Nurses were forced to work in complete darkness, improvising by using their cellphone flashlights to see patients.

The health ombudsman revealed that electromagnetic locks became non-functional, forcing personnel to keep doors open using heavy objects, creating major security breaches that would have allowed mental health patients to wander around unsecured.

Health professionals had to resort to using their mobile phones for official communication due to the infrastructure failures.

Infrastructure in state of decay

The investigation revealed extensive infrastructure problems at the mental hospital.

Mokoena described poor infrastructure maintenance with broken windows creating security risks, blocked sewerage systems, leaking roofs, and sagging ceilings and walls.

“There’s also evidence of original poor workmanship during the construction of the then-new hospital,” he noted.

The hospital lacked emergency equipment and relevant drugs.

“The Northern Cape Mental Health Hospital lacks emergency resuscitation equipment and relevant drugs. Some equipment had flat batteries from not having been charged due to the lack of electricity. Thus, patients could not receive necessary emergency resuscitation with dire consequences,” Mokoena explained.

He cited specific examples where patients Ndimbaza and De Bruin needed resuscitation before being transferred to Robert Mangaliso Sobukwe Hospital, but did not receive it.

“The mental hospital is experiencing acute staff shortages, especially among professional nurses. As a result, the hospital is working at 53% of its commissioned capacity,” Mokoena stated.

The shortage extends to both hospitals, where enrolled nurses and nursing assistants are inappropriately assigned to manage high-acuity units typically requiring professional nurse supervision.

The investigation also found that nursing and medical staff failed to maintain up-to-date patient vital signs and demonstrated generally poor record keeping.

Both hospitals lack written protocols, standard operating procedures, and guidelines for patient management.



Management failures at provincial level

The Health Ombud attributed the crisis to poor professional leadership and inefficient management.

"Both hospitals lack professional leadership, and the management was inefficient and ineffective. "This, in our view, stems from the fluidity and the instability of senior management at the provincial health department level, whereby nearly all senior managers or management posts are filled by acting personnel," Mokoena explained.

Specific cases highlight system failures

The investigation detailed specific management failures in patient care.

Mohoto was referred from the mental hospital for presumed bowel obstruction to Robert Mangaliso Sobukwe Hospital following a telephonic consultation with the surgical department.

Upon arrival, chest and abdominal X-rays revealed no bowel obstruction but showed multilobe pneumonia instead.

A medical officer discharged the patient without treating the pneumonia.

The patient remained in the surgical recovery unit for three days without being seen by any senior doctor from the surgical department until shortly before his death.

"His condition had been deteriorating without anyone, neither the nurses [nor] doctors taking note of this fact and resuscitating him. If his pneumonia had been treated, he might well have been still alive today," Mokoena stated.

Meanwhile, Ndimbaza was found unresponsive in his bed at the mental hospital, suffering from hypothermia and hypoglycemia.

Mokoena said his resuscitation was inadequately executed due to a lack of equipment.

"The post-mortem determined the cause of death was exposure to the elements." Two other patients referred to Robert Sobukwe Hospital received appropriate management before being discharged back to the mental health hospital.



De Bruin had his hypothermia and hypoxia reversed, while Louw underwent a successful craniotomy but remains bedridden with dense hemiplegia.

Additional procurement irregularities and recommendations for urgent action

The Health Ombud team noted additional problematic findings, including superfluous furniture procurement, purchase of golf carts, and inappropriate hospital beds.

It also found delays in commissioning ECT machines, the absence of clinical audits in both hospitals, and overcrowding at Robert Sobukwe Hospital's accident and emergency department.

The Health Ombud recommended that the Northern Cape MEC and head of the health department urgently address staff shortages through recruitment and retention drives.

Mokoena suggested appointing non-South Africans where no qualified locals are available for certain positions.

He said the provincial health department should take appropriate action against the provincial supply chain management for failing to address quality issues with pyjamas and garments supplied by Tropical Enterprise.

The investigation recommended redirecting superfluous equipment to other hospitals that can utilise the materials effectively.

Mokoena also recommended that both hospitals develop comprehensive standard operating procedures, guidelines, and protocols to guide health personnel in patient management.

Minister calls for professional council investigation

Health Minister Dr Aaron Motsoaledi expressed concerns about the findings and announced plans to refer the matter to professional councils for further investigation.

He announced that the national health review committee will visit the two hospitals.

"I'm wondering why some are being referred for training; they've been trained [before, and] they've passed. In-service training is important but I'm not sure whether we should sentence people just for training when they've done something that is so grossly wrong. I'd like to refer the whole stuff to the health profession's council and the nursing council," Motsoaledi said.

The minister emphasised that professional councils must determine whether the actions were professionally appropriate.

He stated that the failures were unacceptable even by his standards as someone who hasn't practised medicine in more than 30 years.

Infrastructure problems date back to construction

Motsoaledi revealed that infrastructure problems at Kimberley Mental Hospital stemmed from its original construction.

"Coming to the issues of infrastructure, it was unfortunate [that] when this hospital was built, it was chaos; in fact, some people are serving sentences because of what happened when Kimberley Mental Hospital was built," he stated.

Years ago, senior engineers discovered that one of the multi-storey buildings lacks proper foundation. The minister emphasised that cable thieves should understand they are committing murder in addition to theft.

He said when load shedding initially began, the department instructed hospitals to hire engineers to maintain electrical systems and generators.

"For vandalism to occur years later and find that the hospital cannot stand on its own is not surprising," Motsoaledi said, calling the situation clear negligence on issues that could have been prevented with proper guidance.

Progress on solutions already underway

The minister noted that some problems have already been addressed, including the hiring of nurses. However, he highlighted ongoing procurement issues, particularly regarding linen quality from Tropical Enterprise.

"I am happy that some of the problems have already been resolved. Like the hiring of nurses, I know it has started, but there is another issue that I cannot fail to mention: the issue of buying linen. You said there must be a forensic investigation professor on procurement. Now you are mentioning Tropical Enterprise, which produces poor quality pyjamas," Motsoaledi said.

He proposed utilising Department of Labour units in Silverton and other provinces, staffed by people with disabilities, that produce high-quality garments and pyjamas.

These units, present in all provinces except Mpumalanga, consistently produce excellent quality items.

R6.7 billion allocated for healthcare improvements

Following a comprehensive assessment, the department identified needs totalling R1.4 million, including beds, linen, mattresses, and pressure mattresses, costing R1.3 billion.

According to Motsoaledi, the Minister of Finance allocated an additional R6.7 billion to the health department in the recent budget.

Motsoaledi said he met with MECs to plan the allocation of these funds. The first priority involves hiring 1,200 doctors, 200 nurses, and 250 other healthcare professionals.

The second priority addresses purchasing the R1.4 million articles, including linen, pyjamas, and other essential supplies.

The recommended interventions, coupled with additional funding, aim to prevent similar tragedies in the future.



WWW.DOCWEB.CO.ZA

DOCWEB



WEB TRAFFIC INCREASES EXPONENTIALLY

Summary					
Reported period Month July 2025					
First visit 01 July 2025 - 00:16					
Last visit 31 July 2025 - 23:54					
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	1,117	1,467 (1,3 visits/visitor)	26,8 (3,63 Pages/Visit)	30,526 (26,8 Hits/Visit)	19,28GB (19063,28 KB/Visit)
Not viewed traffic *			18,023	29,95	9,52 MB

Summary					
Reported period Month August 2025					
First visit 01 August 2025 - 00:16					
Last visit 31 August 2025 - 23:54					
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	1,586	2,456 (1.54 visits/visitor)	12,15 (4,94 Pages/Visit)	41,551 (16,91 Hits/Visit)	14,36GB (6131,18 KB/Visit)
Not viewed traffic *			9,651	25,17	11,88 MB

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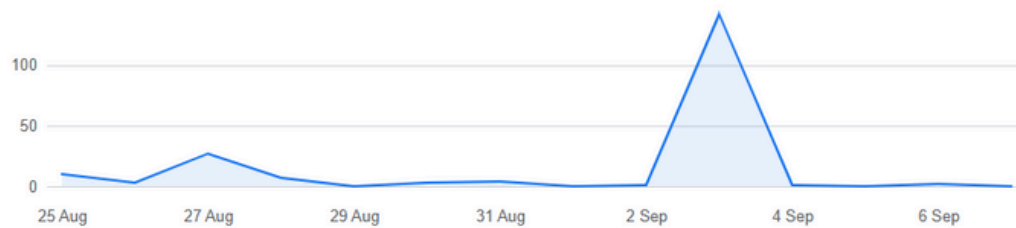


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200 Views ⓘ

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Unfollows ⓘ

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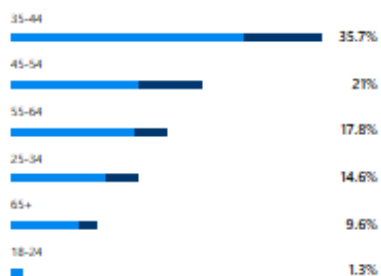
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Age and gender ⓘ

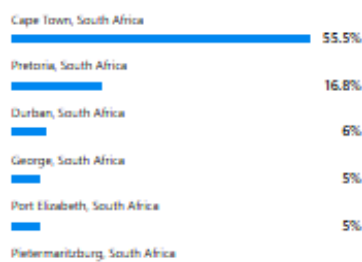
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● Women ● Men ○ Unknown



Towns/cities ⓘ

Lifetime



Countries ⓘ

Lifetime





Invitation to Dentists, Physiotherapists and Allied Health Care Professionals to become an Associate Member of CPC/QUALICARE

Dear Colleagues,

As we approach the new era of increased Government involvement in Health Care Delivery, we anticipate an increase in the speed of implementation of NHI Holding membership of the CPC/Qualicare Network, the largest and most widely representative Medical Network of Healthcare Providers in the Western Cape comprising Doctors, Dentist and Allied Health Care Professionals alike will, we believe, stand in good stead as Government looks to setting up the new Health Care Delivery system for South Africa.

Associate members of CPC/Qualicare offers you the following opportunities:

- Full access to our Monthly newsletter in electronic format.
- Free advertising in our monthly newsletter of your practice related information (max 200 words).
- Free advertising for a locum service, with no commission charges payable.
- Reduced fees to attend our CPC/Qualicare function, at Associate Member's rate.
(Approximately 30% lower than Non-members rates)
- CPC/Qualicare is committed to providing our members and shareholders with all of their CPC requirements each year. Associate Members receive reduced cost of CPD offerings and other CME offerings compared to non-member rates.
(Approximately 30% lower than non-member rates).
- Free listing your practice as part of CPC/Qualicare's Western Cap Electronic Network, your practice will be listed as part of CPC/Qualicare at no charge.
(Worth R6000.00 per annum)
- 2 Free stationary items worth R150.00 per month in the form of 1 Prescription pad - 100 leaves, 1 Sick certificate pad - 100 leaves and the ability to purchase further stationary at 30% below current market prices.
- Preferential rates on certain Practice management software systems depending on vendor.
- Inclusion into the CPC/Qualicare Mass email service to receive important health care updates.
- Certain personal banking offerings from commercial banks.
- NHI future possibilities for your practice...Watch this space as NHI starts to roll out!!
- Preferred wholesale and facilitation of opening new accounts with them.
- Assistance with registration of an Integrated Pollution and Waste Information System IPWIS off the Western Cape Government.
- Assist with late medical aid payments, claw-backs, and withholds, as well as advice on practice admin and responses to forensic investigations.

Cost of Associate Membership

- Dentist R332.00 VAT inclusive, per month
- Allied Health Care Professionals R332.00 VAT inclusive, per month

All fees payable by debit order only. Minimum membership period is 12 months with a 3-month notice period thereafter.

Please note that we also offer reduced membership fees for **first time Medical Practitioners (GP's) in private practice** for their first year of membership.

Should you be interested in this offering, please email Louna at pa@cpqualicare.co.za and one of our 5 consultants will make contact with you shortly.

Warm regards,

Dr. Tony Behrman, CEO of CPC/Qualicare

Dr. Solly Lison, Chairman of CPC/Qualicare



Q/Care Consultants follow-up on queries?

DH Response:

- It is important that the practices send their queries directly & include the Q/C-consultant. If no feedback or reasonable explanation is received within the turnaround time, the consultant may escalate the matter to Anand via email. Here we ask for all reference numbers and email traces.
- Please note that this query was submitted during a time when our team had limited capacity to assist with first-time queries. During such periods, we rely on practices to follow the established channels to ensure all queries are properly recorded and responded to with the quality and consistency we strive for.
- While we are always eager to support our practices, we must also ensure that our processes are respected so that we can maintain high standards across the board.

As a reminder, our channels are as follows:

- General Escalations / Unpaid claims queries: healthpartnerinfo@discovery.co.za (TAT 2 working days) (direct line: 0860445566 for urgent assistance, here we also have managers available for Drs to discuss) - Network applications, provider registrations, administrative queries: provider_administration@discovery.co.za (TAT 2 – 4 working days)

How does a practice go about terminating a DISCOVERY contract? ÓR getting 'off' the DH GP Network?

DH Response:

Should a provider wish to resign from a Network they should send their request, in writing, to provider_administration@discovery.co.za (There is a 30-day notice period)

Please clearly indicate which network they would like to end. They will get feedback within three to four working days.

Please note, some networks influence the direction of claims payment. **So, for providers not on a Network that bill above the Scheme Rate, claims will pay to the member.**

Health ID app stalls, etc. ...

DH is aware of this problem due to all the complaints. The Health ID app frequently stalls and delays doctors' workflow. Many doctors complain about it.

DH response:

- *We sincerely apologies for the inconvenience caused. Our technical team is fully aware of the intermittent issues affecting HealthID and is actively working to ensure the platform remains stable and accessible for daily use in practice.*



Diabetes Reports initially incorrect:

Diabetes Blood results were not pulled into the doctor's reports!

DH acknowledged this & will process new data.

Dr's experience considerable delays as a result.

DH response

- Our sincerest apologies for the delay in sharing the updated reports. We experienced a few delays in finalising the data to ensure we have the most accurate information.
- When sharing our latest report, we have communicated the appeals process where Drs are able to provide us with additional test results and appeal the data on the report.
- We will reach out to these Dr's to discuss the process with them.

DH Introducing Secure Website access:

Many Dr's are UNHAPPY as this makes it so complicated!

The initial phase did **NOT** go 'well' with the 'security update'; the initial login was a time-consuming The OTP was significantly delayed'

DH response:

- As part of our ongoing commitment to protecting your practice's information and complying with the Protection of Personal Information Act (POPIA), we're making important security updates to how you and your teams access Discovery's digital platforms in 2025. These changes are essential for enhancing security and ensuring uninterrupted, secure access to the support services you rely on. Your involvement in this process is key to ensuring a seamless transition for your practice/s.
- From 24 July 2025, access to the Healthcare Professional Zone (HP Zone) will be protected by multi factor authentication (MFA). This extra layer of security means that users will need to verify their identity using two or more methods in addition to their username and password – offering you greater peace of mind when working online.

Note: We'll also be introducing MFA to the HealthID platform soon. Lookout for future communication.

- We're also enhancing telephonic access security. Soon, your registered team members will receive OTPs via our IVR system when they call us. Entering the OTP will help us verify their identity and protect sensitive information from unauthorized access.
- **Thank you for taking the time to review and action this important update. By making sure we have the right documentation and your latest contact details, you're helping us protect your practice and continue providing seamless service and support.**

DH declines payment for a procedure which was approved by them.

Unfortunately, it appears that the code was still to be evaluated and payment was withheld.

I find it hard to comprehend how a fund can authorize a payment but then not pay for a code they approved.

DH Response:

- *We understand your frustration regarding the discrepancy between authorization and payment for procedure code 4849 (excision of malignant lesion of face < 2cm). While the procedure was authorized, the initial feedback indicated that the code was still under evaluation, resulting in non-payment, despite its clinical appropriateness and cost-effectiveness compared to alternatives like code 0307.*
- *We acknowledge that this is not the first time you've encountered this issue, and we agree that it should not require extensive effort to resolve a procedure that was pre-approved. We are pleased to confirm that the procedure has since been paid for following your discussion with Anand. However, we recognize that the process should be more streamlined and transparent.*

Please rest assured that we are reviewing internal workflows to ensure that:

- Authorization decisions are aligned with payment protocols.
- Clinically justified codes like 4849 are not flagged unnecessarily.
- Providers are not penalized for choosing cost-effective, technically demanding procedures.

We appreciate your feedback and will escalate this pattern to the relevant teams for further evaluation. If you encounter similar issues in future procedures, please feel free to reach out directly, and we will assist promptly.



Qualicare Electronic Doctor Network.

Free electronic listing (valued at R6,000.00 per year) of your practice, geographic location, special areas of interest and pictures of your practice can be featured on our Electronic Doctor Network which is only available to CPC/Qualicare Members and Shareholders!!

Our highly successful electronic doctors network see www.qualicaredoctors.co.za has rapidly expanded across the Western Cape Province, and to date has approximately 200 doctors.

As a Member or Shareholder you are still entitled, **at NO charge**, to list your practice on the “EDN” showing your name, practice name, GPS coordinates, areas of special interests, and any specific features which you would like to bring to the attention to prospective patients then please complete and return the form below at your earliest convenience should you be interested to join the growing network.

This is a limited offer open only to Shareholders and Members which is worth over R6,000.00 per year and is brought to you as a member or shareholder benefit at no charge.

Practitioners Details

*** Compulsory to complete – for a successful listing.**

*First Name: _____

*Surname: _____

*Professional Degrees e.g. M.B.ChB. _____

Professional Body Memberships: _____

*HPCSA Number: _____

*Board of HealthCare Funders PCNS Number: _____

DOH Disp Lic Number (if applicable): _____

Areas of Special Interest and Focus: e.g. Paediatrics, Bariatrics, Occupational Health: _____

Contact Details

*Contact Number: (Practice) _____

*Email Address: _____

*Alternative Number: _____

Fax number: _____

Practice Details

*Practice Name: _____

Group PCNS: _____

*Practice Address: _____

GPS Location: _____

Please also provide:

1. **Photo of yourself** - So that the patient can familiarize themselves with the Dr they are going to see.
2. **Photo of the outside of the Practice** – So the patient will recognize the correct building and know what to look out for when coming to visit the practice.
3. **A short bio – interests, hobbies & education** – This gives the patient some trust as they will feel they know you and will feel at home.

Please feel free to contact Annerè van Pletsen CPC/Qualicare Consultant at annere@cpcqualicare.co.za

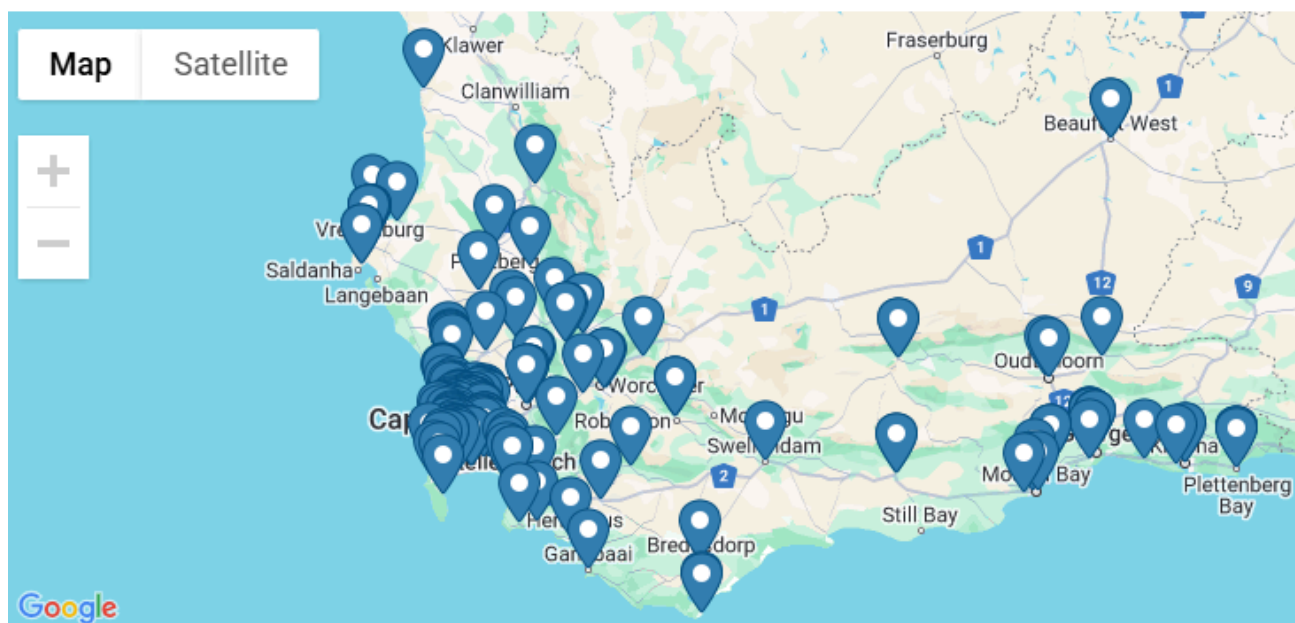
I permit CPC/Qualicare to list my name, surname, the name of my practice, my practice details, and further details provided by me in this application, and my GPS Coordinates on the “*Electronic CPC/Qualicare Doctor Network*” at no cost to me or my practice (tick the appropriate block).

Yes I do agree to the above, in terms of POPIA Act 4 of 2013

☐

Click on the link to complete the form:

<https://www.qualicaredoctors.co.za/new-form/>



Disclaimer:

The entire contents of the CPC/Qualicare Newsletter is based upon the latest and most up to date information at the time of sending.

Due to the fluency of the situation, information changes daily. Please visit our website for more updated information.

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Images & Articles:

Article:

1. <https://www.sabcnews.com/sabcnews/new-evidence-arises-in-corruption-case-against-digital-vibes-mkhize/>
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(b) <https://www.spotlightnsp.co.za/wp-content/uploads/2020/02/HEALTH7.jpg>

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South Africa's pharmaceutical industry stands at a crossroads. The economic headwinds of sluggish growth and currency volatility, combined with the systemic shock of the NHI Act, are forcing a fundamental re-evaluation of business models. The industry's future success will be defined by its ability to navigate this new landscape, pivot to a high-volume, low-cost model, and leverage technology to

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THE END