August 2023

QualiCare

Newsletter

"National Health Insurance"

Special Points of Interest

- **Point 1** Andrew Kenny: Assessing the UK's NHS against the potential NHI Bill
- **Point 2** NHI is already sending South African doctors and nurses out the door
- **Point 3** SA doctors 'implore' NCOP to reject NHI Bill in current form

"National Health Insurance":
"Social Health Insurance and not National Health Insurance"

These are the words which are currently most prominently on the minds of the majority of the forward-thinking South Africans who currently purchase their own health cover.

They range from doctors, dentists, other suppliers of health services, graduate professionals and captains of Industry, those with technical qualifications and diplomas, through to the average employee of the corporates, industrial giants and smaller businesses, all of whom enjoy quality private healthcare through current membership of a medical aid.

9.3 million of them to be exact, amongst which are the 5 million meaningful taxpayers in RSA who fund 90% of the fiscus (excluding VAT and Petrol tax!) for the 63 million population.

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The new NHI bill includes draconian measures to remove the right of freedom of choice of its citizens when it comes to selecting a health care provider, going as far as stating that when NHI is fully functional it will not be permitted for a medical aid to offer a member any reimbursement for a service which may have acquired outside of the NHI!

Furthermore, the utterances that doctors will be paid on a capitated basis, when no such capitation amount has even been mooted, nor has the medical profession been asked to present what their capitation needs would be in order to remain in practice and breakeven, suggests a heavy handed, top down and secretive approach, despite the sugar coating by the spin doctors of the DOH.

They now want to coax GP doctors into allowing themselves to be inspected by the Offices of Health Standards Compliance, so that they can trumpet that they have a cohort of ready and willing primary care practitioners, able and keen to accept the (as yet unnamed and untested) capitation fee, and contract with the state for NHI patients and then feed this to a gullible (?) electorate before 2024!

Add to this the almost certainly anti-constitutional concept of a "Certificate of need", colloquially referred to as the CON, compelling doctors to work only in an area. where the State requires their services, and thereby causing mass negativity both in the medical profession as well as in those consumers of their care.

You would be forgiven if you postulate that this NHI bill, if signed into law, will be snarled up in the courts for years to come!

In the meanwhile, worried well are voting with their emotions, and applying for health and tax clearances in preparation for emigration to the UK and Canada! These are the very young and middle-aged people who make up the largest percentage of the meaningful tax paying base in RSA!!

National Treasury has not uttered a peep in support of the NHI and remember that they are the ones which will be footing the bill which will run into multiples of hundreds of billions of rands more than they currently have got.

"No worries "the NHI drafters say because it will be funded by an extra 3 to 6 % payroll tax amongst other new taxes, which will be paid by the very persons who are losing their quality healthcare to the NHI and are preparing to wave RSA goodbye!

And, if this is all a pre- election ploy to win the hearts and minds of the more easily swayed of voters , to get their votes for the current incumbents who may hope that they have delivered a concept (and that is all the NHI is currently) , we have no doubt that the financial injury to the country in loss of the very persons who pay to keep the lights on and the water running , as well as no chance of attracting new talent into RSA, will result in no more than a Pyrrhic victory for the authorities.

Let's rather insist on the sensible approach that the state fix its ruined public sector healthcare system first. After all, that must be why some of our most senior statesmen need to go to Russia to receive the best quality healthcare, surely?

It is time for the profession to stand up and be counted and raise its voice loudly in every forum!

Social Health Insurance makes sense, National Health Insurance does NOT!

QC Team

END

ANDREW KENNY: ASSESSING THE UK'S NHS AGAINST THE POTENTIAL NHI BILL

As the UK's National Health Service (NHS) celebrates its 75th anniversary, Andrew Kenny reflects on his personal experiences with the NHS and questions its effectiveness. While capitalism has proven successful in many areas, he argues that public health may not thrive under a purely profit-driven model. Examining the potential implementation of South Africa's National Health Insurance (NHI), Kenny expresses concerns about its detrimental effects on private healthcare and suggests practical alternatives for improving public health.

NHI (South Africa) and the NHS (Britain)

By Andrew Kenny *

The National Health Service (NHS) of the UK was born 75 years ago, on 5 July 1948. I was born a month before, on 5 June 1948 in a maternity clinic in Glasgow. My father was directly responsible for one of these births and indirectly responsible for the other.

South Africa might be expecting the birth of her own National Health Insurance (NHI). How successful has the NHS been, and how successful might the NHI be? Will the NHI improve the disastrous state of most South African public health, or will it make it even worse?

I have some strong views on these matters and one confident solution, but I also have a lot of confusion. I find this an extraordinarily difficult matter.

Here's the problem. In most economic and political questions, capitalism with democracy is the best solution. By this I mean free elections, free enterprise, free trade, property rights, the rule of law and limited government.

Capitalism in the last two centuries has delivered to the world unprecedented prosperity and good health.

*Andrew Kenny is a writer, an engineer and a classical liberal.

10th July 2023 by Editor BizNews

UK's NHS against the potential NHI Bill.....continue to page 4

But there is one area, namely electricity generation, where a private company can never do better than a good state company. This is straightforward. And another area, namely public health, where pure capitalism might not deliver the optimum outcome, in fact might deliver a bad outcome. This is anything but straightforward.

Let me repeat myself on electricity generation, since a Daily Friend article on this by another author misinterpreted me some while ago. Here is the thing. Private enterprise is usually better than state enterprise because it is more flexible, more inventive, quicker in thinking and action, and more single-minded (it worries only about delivering a better product to increase its profits, and not about political considerations).

You don't need any of these advantages to buy and run a power station. All you have to do is turn generator shafts at 50 cycles a second for a long time. But you do need an enormous amount of capital. The state can always raise capital more cheaply than the private sector and is content with a low return on capital and a long payback period. Therefore, no private generator will ever be able to compete against a well-run state generator – although of course it should be allowed to try. Eskom is no longer well-run; it is very badly run. Private companies might well do better, and should be free to try. This is a simple argument.

Maximise its profits.

There is no such simple argument in the case of private enterprise and public health.

A private company seeks to maximise its profits by giving customers what they want as cheaply and efficiently as possible. Doctors, like the rest of us, are driven by conflicting motives: the desire to serve, the desire for high status, the desire to make as much money as possible.

Neither the desire to maximise profits nor the wish to give patients what they want will necessarily result in a good outcome for the patients' health. (By 'good outcome', I mean a long, healthy and active life.) It might result in a disastrous outcome.

Many patients do not want to be told by a doctor they need to do more exercise and eat healthy food. They want to lounge about, eat junk food and take a lot of prescription pills (especially if they can get them on medical aid).

UK's NHS against the potential NHI Bill.....continue to page 6

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So they will go to the pill doctor, and he will make money by ruining their health. The drug companies will also make a lot of money from the pills, some of which are positively harmful.

At every factory I have ever worked at, there was a problem of absenteeism on Fridays. A perfectly healthy worker, trying to get a long weekend off or join his chums at a Friday evening celebration, will try to get a sick note from a doctor.

A scrupulous doctor will refuse him, so he will go to an unscrupulous doctor, who will give him one, and so make himself a bit richer.

In May 1945, the Germans surrendered to the Allies in WW2. The victorious British PM, Winston Churchill, called for a general election. It was held on 5 July 1945. Churchill expected to win by a landslide. He lost by a landslide. Those who had risked their lives fighting the Nazis for him voted heavily against him and his Tory Party. They voted heavily for Clement Attlee, a quiet, decent, rather mousey man, and his Labour Party.

My father, who had been dodging U-boats in a merchant ship on the Atlantic bringing grain from Canada to England, voted with them. He explained that though they all loved Churchill and regarded him as a hero and were stirred by his speeches, they had had enough of his system. They cared nothing for his British Empire. They were sick and tired of his class establishment. They voted for Attlee and the Labour Party, and his promises of socialism, especially socialism of public health.

In 1942, William Beveridge, a government economist, had drawn up a report on the rebuilding of British public health after the war. It formed the basis for the NHS, which serves Britain still. (Churchill, an upper-class liberal at heart and a reformer, was quite happy to keep it when he returned to power in 1951.)

Not very highly

After 75 years, how do I rate the NHS? Not very highly, I'm afraid. I was an infant in Britain from 1948 to 1953, then emigrated to South Africa, lived in England from 1972 to 1982, then in SA ever since.

My health is quite good, and I only had a few encounters with the NHS while I was in England, but they weren't very happy ones. Its dentistry was pretty awful, not nearly as good as SA dentistry in my experience. The few times I saw a doctor I got off-hand and unfriendly treatment. The main aim of the doctors, who hardly looked at me, seemed to get me out of the surgery as quickly as possible.

The NHS probably killed an uncle of mine. He had serious cancer but would have responded to proper medical treatment. One night he took a very bad turn. His wife, my aunt, phoned the local hospital, about a mile from their house, telling some NHS bureaucrat there that he needed an ambulance urgently. She described his symptoms. The NHS man scoffed at her, saying she didn't know what she was talking about.My aunt, then retired, told him she was a senior theatre nurse with decades of hospital experience, including caring for the wounded in the war. He sneered and put down the phone. My uncle died.

This is all anecdotal of course, but the statistics paint a worse picture. In 2019, life expectancy in the UK was rated 17th out of 19 countries with comparable economies, breast cancer survival rate was 15th out of 18 countries, colon cancer survival worst out of 18 countries, lung cancer 17th out of 18. The UK had the worst outcome for ischaemic strokes out of nine countries and came 15th out of 18 countries for babies stillborn or dying within seven days. And so on.

In only a few categories did the UK do well. Morale among the NHS medical staff – doctors, nurses and ambulance staff – seems at an all-time low, with doctors, dentists and nurses suffering from overwork and depression, with a high suicide rate. There seems to be an increasing shortage of doctors per number of patients, and – sigh! – an increasing number of managers and administrators. (Does that sound familiar?)

UK's NHS against the potential NHI Bill.....continue to page 7

NHS doctors, nurses and ambulance staff are now on strike, and seem determined to stay on strike until the government addresses their concerns. My feeling is that the blame for this lies not with the doctors and nurses, not even with the UK government (appalling though it has been in recent years) but with the NHS itself. It just isn't a very good model for public health.

Even worse

Public health in the USA, the richest, most powerful nation on Earth, is even worse. On the one hand, the USA offers the best medical treatment you can get anywhere if you can afford it, and spends more per person on public health than anywhere else; on the other, it has a horribly confusing health system and some of the worst health outcomes anywhere.

There is no federal public health system. Individual states offer free healthcare to everyone, but with a limited service. Life-expectancy is even lower than in the UK; in 2019 it was only 76.4 years. The USA has terrible rates of obesity, diabetes and drug-overdosing. Opioids (medical narcotics), used for depression and pain, are horribly over-prescribed, resulting in fat profits for the drug companies who make them, and a high toll of death, dependency and ruined health for many of those who use them. (Remember the Rolling Stones with 'Mother's Little Helper?'

'And though she's not really ill, there's a little yellow pill. She goes running for the shelter of her mother's little helper.')

I know depression is real and widespread, and drugs can be a great help with it, but they should be used discriminately with the sole aim of improving the patient's health.

Very significantly, the third highest cause of death in the USA after circulatory disease and cancer is iatrogenic, which means caused by doctors and medicines.

The most bizarre medical statistic I've ever heard comes from a Covid-19 comparison between the USA, the most powerful country on Earth, and Haiti, the poorest country in the Western Hemisphere. Haiti has bad public health, high infant mortality from infectious disease and low life expectancy.

The USA had one of the highest Covid vaccination rates on Earth, Haiti one of the lowest. The latest figures I've got, from May 2021, show that the Covid death rate in the USA was 1,800 per million and in Haiti 22 per million. Testing for Covid in Haiti was quite good. There was no lock-down in Haiti and hardly any mask wearing, and people are often crowded together in urban slums. Yet Haiti did spectacularly better than the USA over Covid.

Are we allowed to discuss this extraordinary outcome? Probably not. The Covid tragedy looks worse and worse in retrospect but there is increasing pressure on people not to talk about it.

The pandemic was treated in the worst possible way by governments around the world, and the drug corporations were extremely dishonest in their aggressive campaign to make huge profits by foisting untested vaccines on the public rather than allowing the usual medical treatment of previous pandemics. Pfizer, with the full support of the FDA, tried to suppress its own data showing the adverse effects, including death, of its own Covid vaccines.

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Best blend

However, the Covid tragedy is not really pertinent to this article, which tries to find the best blend between private enterprise and the state for public health. In the case of Covid, both governments and drug corporations behaved shamefully, and caused terrible harm.

The ANC's proposed NHI is simple to analyse. It will be a catastrophe. It will destroy private healthcare and reduce all healthcare in South Africa to the level of that in the disintegrating hospitals in the Eastern Cape.

By far the best study of the NHI comes from Dr Anthea Jeffery of the IRR in Chapter 14 of her new book, 'Countdown to Socialism: The National Democratic Revolution in South Africa since 1994'.

She not only tells why the NHI will be disastrous but offers good, simple, practical alternatives. The false ANC rationale for the NHI is this. Most of the money on healthcare is spent on the minority of people who use private health, and so NHI will let all the people benefit equally from the total money spent.

The fallacy of this argument lies in the fact that most of the money for health does not come from taxes. All tax money for health goes to state health. The money for private health comes from individuals after tax.

Under the NHI they won't be allowed to use their own money to pay for private medical schemes, because these will be squeezed out. Instead, they will be compelled to pay more of their money to NHI.

From all of history of the ANC in power, we know exactly what the NHI will entail: a massive increase in hospital bureaucracy, which will be run by highly paid, underqualified ANC cadres; procurement of shoddy but extremely expensive hospital equipment and medical supplies from BEE contractors; very, very long waiting times for patients; filthy wards and hospital beds; massive corruption such as happened at Tembisa Hospital (for reporting which, Dr Babita Deokaran was murdered); and an exodus of doctors and nurses. It will further spur emigration, already at high levels. All this we know.

What I don't know is where the ruling class elite (ANC, EFF and SACP leaders) will go for their health care. They now go to private hospitals or skip the queue and get special treatment in the few good state hospitals. When the NHI has ruined them all, where will they go? Robert Mugabe always went out of Africa for his medical care. Perhaps they'll do the same. Maybe private hospitals will be set up in bordering countries for the elite.

UK's NHS against the potential NHI Bill.....continue to page 9

Doctors and drug companies

As I say, what people want and what doctors and drug companies want to provide is not necessarily for the best health outcomes. The huge improvement in human health in the last hundred years or so comes mainly from cleaner water, better sanitation, better food, warmer houses, less crowding, and more opportunities for sport and physical recreation, and only to a lesser extent, although an important extent, from medical science.

Most illness can be overcome by clean living. Some cannot. The healthiest man in the world will die if he is infected with the HIV virus unless he takes an ARV drug. Once you've got TB you will probably die unless you have antibiotics. Usually, though, diet and exercise are more important than medicine. But some people don't want exercise and healthy foods; they prefer loafing around and eating lots of delicious junk food: chocolates, doughnuts, chips, waffles with syrup, fried everything, double-sized burgers, gallons of Coke, refined white bread only. Should they be compelled to change their ways, and who should compel them?

I have got only one good clear idea about how to improve public health, and I've copied it from Anthea Jeffery. As a capitalist I believe in limited government that only performs essential duties, such as collecting taxes, administering the judiciary, protecting the currency, providing police and armed services, and helping those who cannot help themselves.

The very poor cannot afford to pay doctors, so there must indeed be free state-run healthcare or free state-funded healthcare outsourced to the private sector by competitive bidding. It must be cleaned up and made honest, if this is possible under the ANC. BEE, affirmative action, transformation, cadre deployment and all the rest of the ruinous racist nonsense must be scrapped.

The private health sector must be entirely free to do what it wants. Any qualified doctor must be free to set up practice wherever she wants, without a stupid 'Certificate of Need' (as Ivo Vegter has so eloquently pointed out in the Daily Friend). Any private medical aid scheme or private medical insurance scheme must also be free to set itself up under any terms and conditions it chooses. If it wants to serve only healthy young people and charge them very little, fine. If it wants to include elderly people and people with chronic disorders but charge them a lot of money, fine. If it wants to insure only against certain dread diseases and certain serious accidents, fine. If it wants to insure against all diseases, including dental decay, and charge a huge amount of money, fine.

Could be quite affordable

As Anthea Jeffery points out, private medical schemes are now very expensive because the ANC imposes onerous conditions on them. As she says, private medical schemes could be quite affordable to far more people if only the ANC would remove these conditions. If there were far more private health schemes, the burden on the state health scheme would be much lighter. Public health for everyone in South Africa would improve.

I put my money where my mouth is. 17 years ago, I decided I couldn't afford any private medical aid scheme, and I have not had one since. I have saved a huge amount of money thereby and spent a very small amount of money on private medicine, with a wonderful doctor (female) and a wonderful dentist (male). Under the NHI I should lose both.

Once, when something happened to me on my bicycle at midnight on the top of Chapman's Peak drive and I was knocked unconscious, I received excellent emergency treatment at False Bay Hospital at low cost. If there had been a simple, cheap medical aid scheme 17 years ago, as Anthea suggested, I would have used it. I know I am fortunate to have good health, but I think even if I had had poor health, I would still be better off today under Anthea's scheme. I could not be worse off than under the NHI.

END

NHI is already sending South African doctors and nurses out the door

South African healthcare workers are weighing their options amid anxiety and uncertainty surrounding the National Health Insurance (NHI) Bill – with many considering moving to Canada, which has put healthcare at the top of its critical skills lists.

Speaking to ENCA, Canadian immigration consultant Nicholas Avramis said there has been a notable surge in South African professionals applying to move abroad, especially healthcare workers like doctors and nurses.
Avramis noted that since January 2023, his offices had received around 17,000 enquiries from South Africans looking to move, and a large portion of these has stemmed from the uncertainty surrounding the proposed changes under the recently passed NHI bill.

Canada has recently classified healthcare workers as an essential service, which means they now operate under the Express Entry system.

"Previously, one would have to get a job offer first and then go the work permit route, but now with the critical skills list, one could apply and get selected straight out of the pool," he said.

To qualify as a Federal Skilled Worker, a candidate must have suitable education, work experience, age and English language proficiency. Qualified candidates are selected under the Express Entry Immigration system to apply for permanent residency.

A stand-out benefit for South Africans – which many healthcare professionals may not know – is that local doctors and nurses are exempt from having to get re-certified for practice when they make the move.
Avramis said that the Royal College of Physicians and Surgeons of Canada recognises South Africa's healthcare education – meaning they don't need to get re-certified.
This change, in combination with healthcare professionals' uncertainty and anxiety about the future of healthcare in South Africa, has resulted in many South Africans looking to migrate to Canada, he said.

NHI is already sending South African ..... continue to page 11

NHI is one of the main reasons why South African healthcare workers are leaving

The NHI Bill was rubber-stamped through the portfolio committee on health in May and passed by an ANC majority in the National Assembly in June.

The controversial new laws are now going through the National Council of Provinces (NCOP) for concurrence and will then head to President Cyril Ramaphosa to be signed into law.

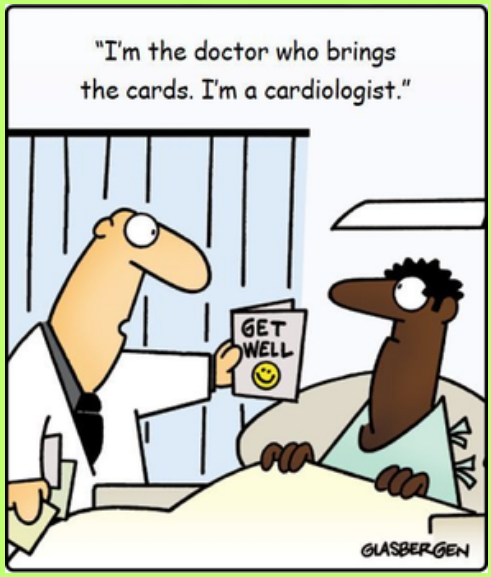
The issues with the bill are plentiful and legal experts, industry stakeholders, consumer groups, business groups, and even parliament's own legal advisors have warned of the many pitfalls it faces – on constitutional and other grounds.

According to Webber Wentzel, two of the most significant pitfalls are how the scheme will be funded and the destruction of private healthcare that it will likely leave in its wake.

Avramis said that this prospect had scared a lot of professionals in the country who want assurance that they will be paid, as well as ensure they receive the best compensation they can get for their intricate and often tiresome work.

"There's a lot of anxiety and mistrust among healthcare workers regarding the NHI – and doctors, who are the tip of the spear in medicine, and nurses, who are the backbone, are professionals who work hard and want to get paid well for their services," said Avramis.

"And in this competitive global market, if there's the ability for them to migrate to a better-paying market, they will do that," he said.



END

SA doctors 'implore' NCOP to reject NHI Bill in current form

- **South African doctors have asked the National Council of Provinces to vote against the National Health Insurance Bill.**
- **The South African Medical Association, which represents over 12 000 doctors in the country, is vehemently opposed to the NHI.**
- **In June, the National Assembly passed the NHI Bill despite strong opposition from the private healthcare industry.**

South Africa's biggest body representing doctors has asked the National Council of Provinces (NCOP) to vote against the passing of the National Health Insurance Bill in its current form.

The South African Medical Association (SAMA), which represents over 12 000 doctors in the country, submitted a petition signed by more than 52 000 to the NCOP – the parliamentary body currently considering the NHI Bill.

The Bill is with the NCOP after, in June, the National Assembly passed the NHI Bill despite strong opposition from the private healthcare industry and leading opposition parties.

According to SAMA, it has been involved in the legislative process of the Bill from its inception.

In a letter to NCOP chairperson Amos Masondo, SAMA chairperson Dr Mvuyisi Mzukwa said they had made written and verbal representations to Parliament outlining concerns regarding the Bill and its potential implications.

" Regrettably, our views have been largely disregarded, leading to the adoption of the Bill by the Parliamentary Portfolio Committee on Health in May 2023, and its subsequent adoption by the National Assembly on 13 June 2023. It was thereafter that we elected to exercise our constitutional right to petition the National Council of Provinces as a last resort," he said.

The petition has more than 52 000 signatures and 2 000 comments from the public.

SA doctors 'implore' NCOP..... continue to page 13

SAMA's key concerns include:

- The focus on a funding model without addressing human resource shortages and infrastructure issues in the public healthcare system;
- Corruption risks;
- A lack of cost assessment;
- Limitations on medical aid schemes.

"We believe that the Department of Health's attempt at addressing some of the above mentioned issues in a statement released by the South African Government News Agency on 5 July 2023, after the adoption of the Bill in the National Assembly, is itself an indicator that the Bill, in its current form, does not address those concerns, as a clarifying statement by the Department would otherwise have not been required," Mzukwa said.

The NHI will create a single fund to which those earning an income will contribute, probably through a payroll tax.

As the NHI expands over time, the Bill envisages that medical aids will no longer be allowed to reimburse people for services offered by the NHI and will effectively be phased out.

Several NGOs, medical schemes and other institutions have vehemently opposed the proposed single-payer model, which means that government will buy all essential healthcare products and services.

Under the NHI, medical schemes will only be allowed to cover healthcare that is not offered by the government.

Mzukwa pleaded with Masondo to take a different stance to that of the National Assembly.
"As the final house of Parliament that will decide on the adoption of the Bill before it is signed into law, we implore the National Council of Provinces to consider the concerns raised," he said.

END

NHI KILLING MEDICAL AID COVER WILL CAUSE A REVOLT

Discovery Health CEO Ryan Noach said it is not feasible to wipe out South Africa's private healthcare sector and nationalise it in a communist-like approach.

Noach made these comments during an interview with Biznews founder Alec Hogg regarding the recently passed National Health Insurance (NHI) Bill.

He agrees with the government that the current healthcare situation in South Africa is inequitable and needs change.

Noach added that the NHI has strengths and that most of the National Health Insurance is good and can be worked with.

However, they are concerned about Section 33 of the Bill, which states that when the NHI is fully implemented, medical schemes will not be allowed to provide cover provided by the NHI.

He said preventing medical aid schemes from providing private healthcare to its members and nationalising the system can't be done.

"It will cause a revolt among the current people whose healthcare spending will drop by over 70% per capita," he said.

There is also no way to fund the NHI. "You cannot raise enough taxes for NHI. It is economically not feasible," he said.

Apart from these glaring problems, Noach said introducing NHI and stopping medical aids from providing private healthcare is "just not smart".

"There is such brilliant support from the private sector in this country. We have a national asset. The smartest way is to work with the private sector," he said.

Government ignored constructive engagements

The Discovery Health CEO said they put constructive proposals on the table instead of tearing the NHI down.

He further revealed that there were 112 submissions to the Parliamentary Portfolio Committee on Health.

These submissions included tens of thousands of pages from health economists, civil society, the private sector, and non-governmental organisations.

Despite these valuable submissions, no changes of substance were made to the NHI Bill over four years.

He said he does not know why the government ignored the feedback from all the experts who shared their views.

"It is hard to explain that after so much engagement and consultation, not a single change of substance was made over four years," he said.

"The only rational conclusion is that they had a model they believed in and were determined to push through."

"We just beg that there will be some engagement and collaboration between the government and private sector."

END

BIGGEST FARCE IN THE NHI CHARADE IS THE FUNDING STORY: MAVUSO

BLSA CEO says the National Health Insurance risks doing precisely the opposite of what is being promised to South Africans.

NHI: A cynical attempt to win votes without the hard work of creating a real workable plan, says Busi Mavuso.

NHI is only illogical and absurd from the traditional capitalist perspective. We should remind ourselves that accountability, professionalism, pragmatism, planning, and foresight are inherent to the capitalist system and do not exist in the collectivist system.

The increasing pressure for NHI is quite logical and natural if viewed from the overriding perspective. The main political narrative is redistributive and exploitative per definition.

As seen from the prevailing traditional communalist perspective, resources should be shared, even though it implies that the resource will be degraded and destroyed in the process. This process is best described by the political-economic phenomenon known as The Tragedy of the Commons.

The push for NHI is just another infringement on private property rights. It is equally damaging and absurd as the nationalization of mineral rights, redistributive municipal taxes, BEE requirements, cadre deployment, EE, state capture, construction mafia, etc. NHI is tantamount to the expropriation without compensation of private healthcare and the rights of their members. It is the nationalization of private healthcare.

This is exactly what socialist organizations do when they gain power.

This entire ANC government is a charade, a farce that plunders property under the veneer of democracy while they hide under the banner of social justice and equality.

Biggest farce in the NHI charade ..... continue to page 16

From my comment on an article on the proposed NHI elsewhere:

"In terms of funding, the state has argued that more money is being spent servicing the needs of 14% of the population through private healthcare than what is spent on the vast majority of people through public services. Hence, it aims to pool the money spent on both."

Essentially means that the pool of funds, including my contribution which I pay for my health needs at a fully functional medical practice in my neighbourhood, will now be shared amongst the unemployed (a consequence of the dysfunctional state) and I will have to sit in a queue in some distant overcrowded clinic to get medical treatment?

Welcome to the socialist Third World of ineptitude and corruption.

And "The department has assured that private healthcare will be alive and well under the NHI – just severely truncated and limited to reduce costs." Alive and well? Like Eskom, Transnet, SANRAL, SAA and every other bankrupt SOE? Today on radio I heard that a fishing charter operator cannot get permits for his passengers because the only place that issues them is the Post Office. Try finding a functioning PO and when he did, they did not have enough forms, and the stamp to approve the licence was broken. No lies.

If the NHI sets the fees and medical professionals have to wait for the inept state to refund/pay them, expect a steady emigration of medical professionals to First World countries like the EU, USA and Australia.

> *"NHI will be funded through a mandatory pre-payment system and other forms of taxes collected by SARS and allocated to the Fund by Parliament,"*

So the tiny tax base of the middle class will then be under even greater pressure to support the 30 million non-income paying South Africans on grants, unemployed and unemployable.

"The pooling into one risk pool will ensure appropriate cross-subsidization between the young and old, rich and poor, healthy and unhealthy," it said." No it won't, it will drain the treasury with even more corruption and kill the economy.

Zimbabwe here we come.

END

‘PHAMBILI NHI – BUT WITH CARE AND CAUTION’ AS MAJOR PROBLEMS LOOM

Evidence from pilot schemes points to critical fault lines in SA’s readiness for universal health care

Since the dawn of democracy in 1994, South Africa has committed to a policy of accessible health care for all people. This commitment is enshrined in our constitution under Section 27. However, 29 years later we have failed to implement this commitment and our health system is still underperforming relative to the resources available.

EHealth financing models play a central part in giving direction to the efforts to achieve universal health care (UHC). Evidence from across the globe suggests that countries with well-functioning national health insurance systems and strong economies with a wide tax base, which can spend more on health care, have made greater advances in achieving UHC.

The National Health Insurance (NHI) Bill represents South Africa’s strategy to achieve UHC. While the bill has been adopted by the National Assembly it is not a fait accompli, as it has to be passed by the National Council of Provinces before being signed off by the president.

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In South Africa, NHI was piloted in 10 health districts across the country during 2012-17. The evidence from these pilots points to at least five critical fault lines in the public health system’s readiness to implement NHI. These include shortages in — and the maldistribution of — specialised human resources; a lack of equipment and poorly maintained infrastructure; poor supervision and management practices; and health information systems that lack quality, coverage and standardisation and do not sufficiently support reimbursement and resource management.

Because of these problems, there were few improvements in the quality of health care provided.

‘Phambili NHI – but with care and caution’ ..... continue to page 18

This shows that the public health system in South Africa is not yet strong and resilient enough to fully implement the proposed NHI.

There are many parts of the bill that remain vague and should be urgently clarified if we are to build public support for this policy. For example, the bill does not clarify the set of benefits to be funded under the NHI, the nature of referral networks, or what arrangements will be implemented for contracting and reimbursement arrangements.

Potential consequences of NHI's full implementation include the possible mass emigration of health-care professionals.

A national health technology assessment system must be established to ensure that evidence-based choices are made in regard to the benefits to be funded under NHI. For example, providing a much smaller set of benefits focused on health promotion and prevention in primary health-care settings may be the best approach as it has important longer-term economic spin-offs in averting disease and the accompanying costs of care.

Also, it remains unclear why the government is not better leveraging the substantial technical know-how and strong health information systems in the private medical schemes industry to facilitate the successful implementation of NHI.

It is also necessary to warn against potential unintended consequences of NHI's full implementation.

These include: the possible mass emigration of health-care professionals because of a lack of confidence in the capacity of the government and its financial ability to ensure the success of the service; corruption involving skimming resources from the NHI Fund; poor governance and a lack of accountability constraining NHI's ability to realise its envisaged remit; large numbers of South Africans switching to using only private health-care services, which could put present levels of quality of care under pressure and may see informal payments being charged at private facilities; and the risk of moral hazard resulting in an expansion in the demand for health-care services that exceeds the financial capacity of the fund.

The most pressing questions regarding NHI are the "why, how and when" of its implementation. A reassessment of the health system's readiness to fully implement it should be conducted as a matter of priority, including revisiting the costing around the affordability of the financing model.
Caution is also necessary as an expansive NHI that is not affordable will be difficult if not impossible to roll back, with substantial implications for the delivery of other government services due to the necessary reallocation of budgetary resources and an increasing tax burden on South Africans.

Rather than exclaim "phambili NHI, phambili", the echo should be "phambili NHI, but together and with care and caution". The bill itself refers to such a gradual, progressive and programmatic implementation of NHI.

END

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About us:

In the modern health care industry, finding the right partner to help manage a practice can be a difficult task, Medical Practitioners are overwhelmed with the sheer number of options available.

Fortunately, Grid Wealth has emerged as a leader in the field, offering a comprehensive set of tools for medical practices to manage their operations more efficiently.

Grid Wealth is a Medical Bureau service with over 40 years of experience,we have established a respected track record of delivering quality service to our customers. At Grid Wealth, our mission is to empower Medical Practitioners to create Wealth by providing a comprehensive billing and debtors management service.

Grid Wealth is ideal for medical practices that are looking for comprehensive and reliable billing solutions. We invite you to join the community of satisfied customers who have chosen our services over the years.

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AI and CRISPR ability to precisely control gene expression

CLINICAL LABORATORIES

The convergence of artificial intelligence (AI) and CRISPR-Cas9 technology has paved the way for revolutionary advancements in the field of genetics. One of the most promising areas of collaboration between these two cutting-edge technologies is the precise control of gene expression. This synergy holds the potential to unlock new doors in medicine, agriculture, and biotechnology by allowing scientists to manipulate gene activity with unparalleled accuracy.

Understanding Gene Expression Regulation:

Gene expression is the process by which information encoded in a gene's DNA is converted into functional proteins or RNA molecules. It plays a pivotal role in determining an organism's characteristics, functions, and responses to the environment. To regulate gene expression, cells utilize intricate molecular mechanisms that involve various factors like transcription factors, enhancers, and repressors. However, until recently, achieving precise control over these mechanisms has been a challenging task.

The Advent of CRISPR-Cas9:

Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR) and CRISPR-associated protein 9 (Cas9) form a revolutionary genome editing tool. Initially, CRISPR-Cas9 was predominantly used for gene editing by introducing targeted changes in DNA sequences. However, scientists quickly realized that this technology could also be harnessed to regulate gene expression without altering the underlying DNA sequence. This concept led to the development of CRISPR-based transcriptional regulation systems.

CRISPR-Based Gene Expression Regulation:

CRISPR-Cas9-based gene expression regulation involves utilizing a deactivated Cas9 protein (dCas9) that lacks the ability to cut DNA. Instead of altering the genetic code directly, dCas9 is guided to specific DNA sequences using a guide RNA molecule. Coupled with various effector domains, dCas9 can either activate or repress gene expression by modulating the transcriptional machinery's accessibility to the target gene.

The Role of AI in Optimizing CRISPR-Cas9 Systems:

While CRISPR-Cas9 technology provides the essential framework for gene expression regulation, AI enhances its precision and efficiency. AI algorithms analyze vast datasets to predict the outcomes of different genetic modifications, guide RNA designs, and effector domain combinations. This computational power enables scientists to predict the potential effects of targeting specific gene regulatory regions, making the process of designing CRISPR-based systems more informed and accurate.

AI-Driven Guide RNA Design:

Designing guide RNAs that efficiently and specifically target desired genomic sites is crucial for successful gene expression regulation. AI algorithms, particularly machine learning models, use patterns in existing data to predict the efficiency and specificity of different guide RNA sequences. This process saves time and resources by reducing the need for trial-and-error experimentation. Tools like Elevation, developed by researchers at the Broad Institute, employ deep learning to optimize guide RNA design and improve the precision of CRISPR-based gene expression regulation

Predicting Off-Target Effects:

A major concern in CRISPR technology is off-target effects, where the gene editing machinery inadvertently alters unintended genomic regions. AI-driven algorithms assist in predicting these off-target effects by analyzing the target site's sequence and identifying potential matches in other regions of the genome. Tools such as CRISPR-off use AI to predict and mitigate off-target effects, making gene expression regulation safer and more reliable.

Optimizing Effector Domains:

CRISPR-based gene expression regulation relies on effector domains that are fused to the dCas9 protein to modulate transcription. AI helps in selecting the most effective effector domains by analyzing their interactions with the transcriptional machinery and predicting their impact on gene expression. By simulating the interactions between effector domains and DNA, AI algorithms can guide scientists in choosing the optimal configuration for their specific goals.

Applications Across Fields:

The marriage of AI and CRISPR for gene expression regulation has a multitude of applications. In medicine, this technology offers the potential to treat genetic disorders by modulating gene expression rather than editing the genome itself. By controlling the expression of disease-related genes, researchers could mitigate the symptoms of various genetic conditions. Moreover, cancer therapies could be revolutionized by reprogramming cancer cells to behave like healthy cells through precise gene expression control.

In agriculture, AI-driven CRISPR technology could lead to improved crop yields and enhanced resistance to pests and environmental stressors. By optimizing gene expression in crops, scientists can develop varieties that are more resilient and nutritious, contributing to global food security.

Conclusion:

AI-driven CRISPR technology represents a powerful approach to precisely control gene expression. This collaborative effort allows scientists to fine-tune gene activity with unprecedented accuracy, opening doors to innovative applications in medicine, agriculture, and biotechnology. As AI algorithms continue to evolve and improve, their integration with CRISPR technology will undoubtedly lead to even more breakthroughs in our understanding of genetics and our ability to harness its potential for the betterment of humanity.

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CLINICAL LABORATORIES

Genetic Testing

Hematological Cancers

Cytogenomic testing is a powerful tool for detecting **genetic abnormalities in cancer cells**. By analyzing the chromosomes and genes in cancer cells, doctors and researchers can gain valuable insights into the molecular mechanisms underlying the development and progression of cancer.

A Plus Clinical Laboratories offers **highly accurate and detailed analysis** of the structure and organization of chromosomes. By using high-powered microscopes and sophisticated imaging software, Optical Genome Mapping (OGM) can identify and analyze structural variations in the genome, including large-scale copy number variations, insertions, deletions, inversions, and translocations.

OGM is particularly well-suited for detecting chromosomal abnormalities in hematological cancers, which are **cancers that affect the blood and bone marrow.** Hematological cancers are often characterized by complex genetic changes involving multiple chromosomes and genes, making them difficult to diagnose and treat.

Cytogenomic testing using OGM can provide clinicians with **valuable information** about the genetic makeup of hematological cancers, including the **specific chromosomal abnormalities that are driving the cancer**. This information can help clinicians to **develop targeted and personalized treatment strategies** that are tailored to the individual patient's unique cancer profile.

In addition, OGM can be used to **monitor the progression** of hematological cancers over time, enabling clinicians to track changes in the cancer's genetic makeup and adjust treatment strategies accordingly.

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Lymphoma
MDS
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How do I stop my mind racing and get some sleep?

Martin turns off the light to fall asleep, but his mind quickly springs into action. Racing thoughts about work deadlines, his overdue car service, and his father's recent surgery occupy his mind.

As he struggles to fall asleep, the hours start to creep by. He becomes frustrated about how he will cope tomorrow. This is a pattern Martin has struggled with for many years.

But what's going on when your mind is racing at night? And how do you make it stop?

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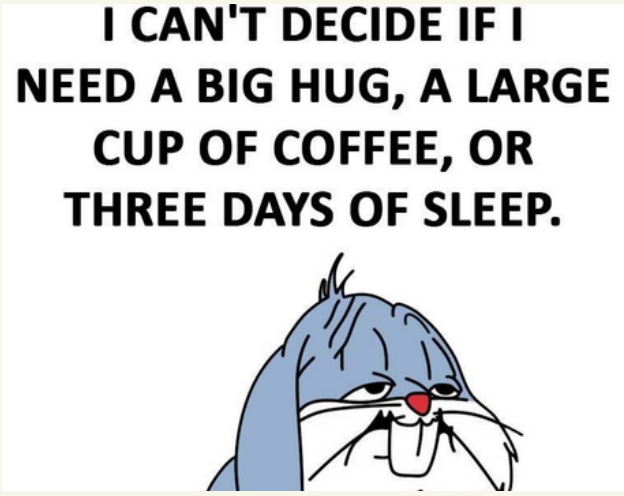
But what's going on when your mind is racing at night? And how do you make it stop?



It can happen to anyone.

In bed, with no other visual or sound cues to occupy the mind, many people start to have racing thoughts that keep them awake. This can happen at the start of the night, or when they awake in the night.

The good news is there are effective ways to reduce these racing thoughts, and to help get some sleep. To do this, let's take a step back and talk about insomnia.

How do I stop my mind racing..... continue to page 23

What is insomnia?

If you are like Martin, you're not alone. Right now, up to six in every ten people have regular insomnia symptoms. One in ten have had these symptoms for months or years.

Insomnia includes trouble falling asleep at the start of the night, waking up during the night, and feelings of daytime fatigue, concentration difficulties, lethargy or poor mood.

Just like Martin, many people with insomnia find as soon as they get into bed, they feel alert and wide awake. So what's going on?

The more time we spend in bed doing things other than sleep, the more our brain and body start to learn that bed is a place for these non-sleep activities.

These activities don't just include worrying. They can be using a mobile phone, watching TV, eating, working, arguing, smoking or playing with pets.

Gradually, our brains can learn that bed is a place for these other activities instead of rest and sleep. Over time the simple act of getting into bed can become a trigger to feel more alert and awake. This is called "conditioned insomnia".

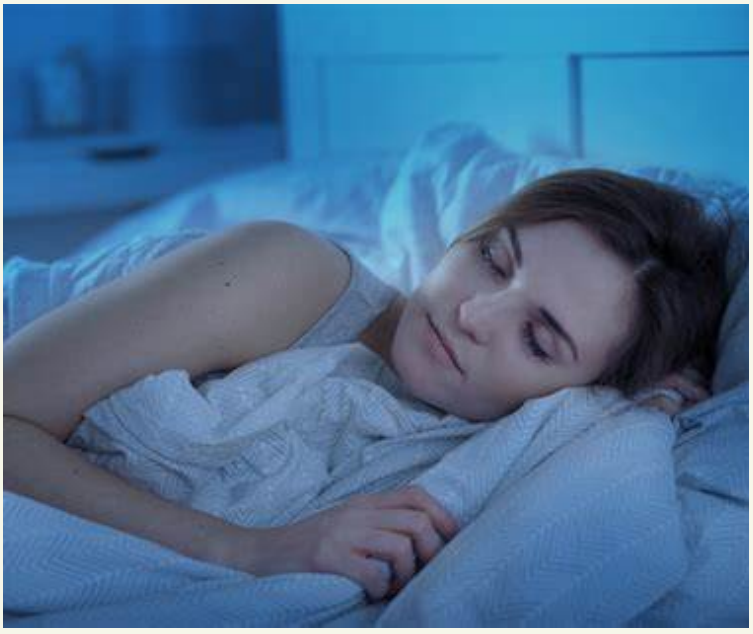
Here are six ways to spend less time awake in bed with racing thoughts.

1. Re-learn to associate bed with sleep

Stimulus control therapy can help re-build the relationship between bed and sleep.

Follow these simple steps every night of the week:

- only use your bed for sleep and intimacy. All other activities should occur out of bed, preferably in another room.
- only go to bed if you are feeling sleepy (when your eyes are heavy, and you could easily fall asleep). If you are not feeling sleepy, delay getting into bed. Use this time to do something relaxing in another room.
- if you are still awake after about 15 minutes in bed, get out of bed and go to another room. Do something else relaxing until you are feeling sleepy again, such as reading a book, listening to the radio, catching up on some chores or doing a crossword puzzle. Avoid anything too stimulating such as work or computer gaming.
- repeat the above two steps until you are asleep within about 15 minutes. This can take several cycles of getting in and out of bed. But during this time, your body's natural need for sleep will increase, and you will eventually fall asleep within 15 minutes of getting into bed.
- get out of bed at the same time each morning, no matter how much you slept the night before.
- avoid long daytime naps, which can make it harder to fall asleep that night.



Over several nights, this therapy builds the relationship between bed and sleep, and reduces the relationship between bed and feeling alert and having racing thoughts.

How do I stop my mind racing..... continue to page 24

2. Distract yourself with fond thoughts

Negative thoughts in bed or worrying about the consequences of losing sleep can make us feel more alert, worried, and make it more difficult to sleep.

So try something called “cognitive re-focusing”. Try to replay a fond memory, movie, or TV show in your mind, to distract yourself from these negative thoughts.

Ideally, this will be a memory you can recall very clearly, and one that causes neutral or slightly positive feelings. Memories that are overly positive or negative might cause an increase in alertness and mental activity.

3. Relax into sleep

Relaxation therapy for insomnia aims to reduce alertness and improve sleep.

One way is to progressively tense and relax muscle groups throughout your body, known as guided progressive muscle relaxation therapy.

You could also try breathing exercises, soothing music, visual imagery or other relaxation exercises that feel right for you.
Part of relaxing into sleep is avoiding doing work in the late evening or screen-based activities right before bed. Give yourself a “buffer zone”, to allow yourself time to start relaxing before getting into bed.

4. Worry earlier in the day

Schedule some “worry time” earlier in the day, so these thoughts don’t happen at night. It can also help to write down some of the things that worry you.
If you start to worry about things during the night, you can remind yourself you have already written them down, and they are waiting for you to work through during your scheduled “worry time” the next day.

5. Know waking in the night is normal

Knowing that brief awakenings from sleep are completely normal, and not a sign of ill health, may help. Sleep occurs in different “cycles” during the night. Each cycle lasts for about 90 minutes, and includes different stages of light, deep, and dreaming (REM) sleep.

Most of our deep sleep occurs in the first half of the night, and most of our light sleep in the second half. Everyone experiences brief awakenings from sleep, but most people don’t remember these the next morning.

6. What if these don’t work?

If these don’t work, the most effective next step is “cognitive behavioural therapy for insomnia” or CBT-i. This non-drug therapy targets the underlying causes of insomnia, and leads to long-lasting improvements in sleep, mental health, and daytime function.

CBT-I is done under the supervision of a doctor, nurse, or therapist and seeks to change for the better a person's sleep-related behavior and thoughts.

END

There has been considerable confusion as to how many out of area visits a Polmed member may enjoy as a result of contradictory messages which have been received by our members.

The following examples are quoted from the '2023 POLMED BENEFIT GUIDE' below:

1) POLMED GP NETWORK (NETWORK GP PROVIDER) MARINE OPTION
Members and beneficiaries are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well. Members are allowed three (3) visits to a GP who is not nominated per annum for emergency or out-of-town situations.

2) POLMED GP NETWORK (NETWORK GP PROVIDER) AQUARIUM OPTION
Members and beneficiaries are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well.
Members are allowed 3/three visits to a GP who is not nominated per annum for emergency or out-of-town situations. A 30% co-payment shall apply once the maximum. out-of-non-nominated consultations are exceeded.

The following extract is from a letter sent by Medscheme Network Contract Management to Qualicare doctors, in which it is mentioned that only 2 "Out -of-Network" visits will be paid:

Reimbursement Guidelines for Polmed Members:

Polmed members have the flexibility to consult any family practitioner (FP) of their choice, whether they are part of the Polmed network or not. Claims for consultations with both network and non-network FPs will be reimbursed.

However, if a Polmed member consults a non-network FP, there is an "Out-of-Network Rule" that applies. According to this rule, the first two consultations with a non-network FP will be paid at the Polmed network rate. Subsequent visits to the non-network FP will be reimbursed at the non-network rate. This rule also applies to the management of chronic conditions.

It thus appears that Polmed members are indeed allowed THREE out of area visits, per year, after which Polmed reimburses the General Practitioner at a reduced rate. The difference should be collected from the patient.

END

Upcoming Events

We are excited to announce the following 2 events!!

Garden Route
Open Day 2023
19th August
Saturday @ 10:45am

Worcester
Open Day 2023
7 October
Saturday @ 10:45am

Conflicting Blood Pressure Targets: Déjà Vu All Over Again

Stop me if you've heard this before. There's a controversy over blood pressure targets. Some argue for 140/90 mm Hg, others for 130/80 mm Hg, and some super ambitious folks think that we should aim for 120/80 mm Hg. If this sounds familiar, it should. We did it in 2017. It's unclear what, if anything, we learned from the experience. On the upside, it's not as bad as it was 100 years ago.

When High Blood Pressure Was a 'Good' Thing

Back then, many believed that you needed higher blood pressure as you got older to push the blood through your progressively stiffened and hardened arteries. Hence the name "essential" hypertension. The concern was that lowering blood pressure would hypo-perfuse your organs and be dangerous. In the 1930s, John Hay told an audience at a British Medical Association lecture: "The greatest danger to a man with high blood pressure lies in its discovery, because then some fool is certain to try and reduce it."

The 1900s were a simpler time when people had fatal strokes in their 50s, and their families were consoled by the knowledge that they had lived a good life. If our thinking around blood pressure had evolved slightly faster, perhaps President Roosevelt wouldn't have died of a stroke during World War II as his doctors watched his systolic blood pressure climb above 200 mm Hg and suggested massages and barbiturates to take the edge off.

The Current Controversy

Not that long ago, 180 mm Hg was considered mild hypertension. Now, we are arguing about a systolic blood pressure of 140 vs 130 mm Hg.

The American Academy of Family Physicians (AAFP) takes the view that 140/90 mm Hg is good enough for most people. Their most recent clinical practice guideline, based primarily on two 2020 Cochrane Reviews of blood pressure targets in patients with and without cardiovascular disease, did not find any mortality benefit for a lower blood pressure threshold.

This puts the AAFP guideline in conflict with the 2017 guideline issued jointly by the American College of Cardiology (ACC), American Heart Association (AHA), and nine other groups, which recommended a target of 130/80 mm Hg for pretty much everyone. Though they say > 140/90 mm Hg should be the threshold for low-risk patients or for starting therapy poststroke, we often forget those nuances. The main point of contention is that the AAFP guideline was looking for a mortality benefit, whereas the ACC/AHA/everyone else guideline was looking at preventing cardiovascular events.

Conflicting Blood Pressure Targets ..... continue to page 28

Guideline	Target BP (mm Hg)		Population targeted	Notes
2023 European Society of Hypertension, European Renal Association, International Society of Hypertension	<130/80		• 18-64 years	Because the Europeans felt compelled to update their guidelines just as I was going to press
	<140/80		• 65-79 years	
	<130/80		• 65-79 years if treatment tolerated	
	140-150 SBP		• ≥ 80 years	
	<130-139 SBP		• ≥ 80 years if treatment tolerated	
2022 AAFP	140/90		• Most people	The source of the current controversy
	135/85		• High-risk folks (if they can live with the side effects)	
2022 National Institute of Health Excellence	Office BP	24h BP		The UK guidelines
	140/90	135/85	• Age < 80 years	
	150/80	145/85	• Age ≥ 80 years	
2020 Hypertension Canada Guidelines	140/90		• Low-risk groups	What Canada thinks (Canada is that country to the north)
	130/80		• Patients with diabetes	
	120 systolic		• High cardiovascular risk	
2020 US Dept Veterans Affairs	150/90		• Age < 60 years	Because sometimes you ask yourself, "What does the US militarily think?"
	150/90		• Age ≥ 60 years	
2017 ACC/AHA	130/80		• Everyone (more or less)	The source of the previous controversy
2014 8th Joint National Committee	140/90		• Age < 60 years	The source of the controversy before that
	150/90		• Age ≥ 60 years	

BP ; SBP

The latter guideline was driven mainly by the results of the SPRINT trial. ACC/AHA argue for more aggressive targets to prevent the things that cardiologists care about, namely heart attacks.

The AAFP guideline concedes that more aggressive control will result in fewer myocardial infarctions (MI) but warn that it comes with more adverse events. Treating 1,000 patients to this lower target would theoretically prevent four MIs, possibly prevent three strokes, but result in 30 adverse events.

In the end, what we are seeing here is not so much a debate over the evidence as a debate over priorities. The AAFP's main focus is all-cause mortality; the ACC/AHA's is cardiovascular events. Interventions that don't improve mortality can be questioned in terms of their cost effectiveness. But you probably don't want to have a heart attack (even a nonfatal one). And you certainly don't want to have a stroke. However, lower blood pressure targets inevitably require more medications.

Notwithstanding the economic costs, the dangers of polypharmacy, medication interactions, side effects, and syncope leading to falls cannot be ignored. Falls are not benign adverse events, especially in older adults.

The counter argument is that physicians are human and often let things slide. Set the target at 140/90 mm Hg, and many physicians won't jump on a systolic blood pressure of 144 mm Hg. Set the target at 130 mm Hg, and maybe they'll be more likely to react. There's a fine line between permissiveness and complacency.

If you zoom out and look at the multitude of blood pressure guidelines, you start to notice an important fact. There is not much daylight between them. There are subtle differences in what constitutes high risk and different definitions of older (older should be defined as 10 years older than the reader's current age). But otherwise, the blood pressure targets are not that different.

Does that final 10 mm Hg really matter when barriers to care mean that tens of millions in the United States are unaware, they have hypertension? Even among those diagnosed, many are either untreated or inadequately treated.

With this context, perhaps the most insightful thing that can be said about the blood pressure guideline controversy is that it's not all that controversial. We can likely all agree that we need to be better at treating hypertension and that creative solutions to reach underserved communities are necessary.

Arguing about 140/90 mm Hg or 130/80 mm Hg is less important than acknowledging that we should be aggressive in screening for and treating hypertension. We should acknowledge that beyond a certain point any cardiovascular benefit comes at the cost of hypotension and side effects. That tipping point will be different for different groups, and probably at a higher set point in older patients.

Individualizing care isn't difficult. We do it all the time. We just shouldn't be letting people walk around with untreated hypertension. It's not the 1900s anymore.

END

Upcoming Events

We are excited to announce the following 2 events!!

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19th August
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Worcester Open Day 2023
7 October
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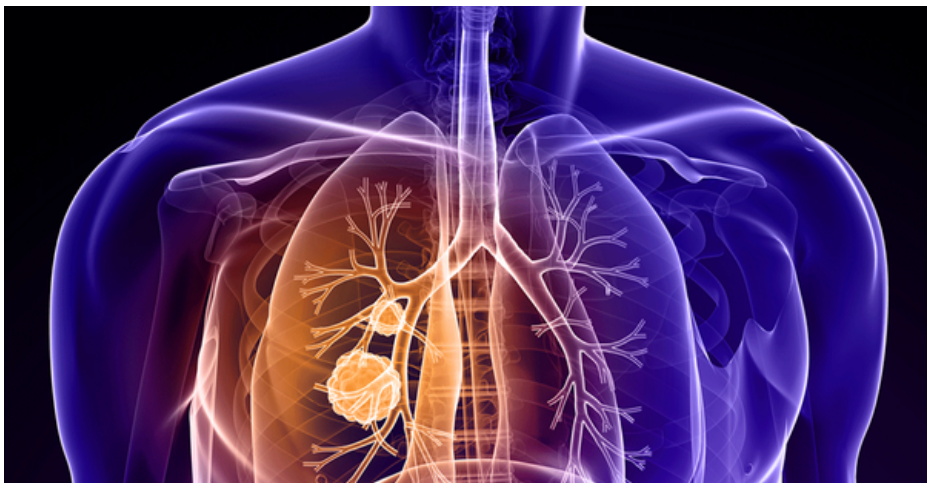
7 signs and symptoms of lung cancer



Lung cancer (LCa) is responsible for 25% of all cancer deaths. Ahead of World Lung Cancer Day (1 August), the Global Initiative for Chronic Obstructive Lung Diseases stresses that although the number of cases has decreased over the past few years as a result of smoking cessation campaigns, more people still die annually as a result of the disease compared to colon, breast and liver cancers combined.

LC is characterised by uncontrolled cell growth in the tissues of the lungs. More than 2.2 million new cases of LCa are reported annually. Furthermore, LCa is responsible for ~1.8 million deaths a year, representing the leading cause of cancer-related dea th.[2][3]

Data from the Cancer Association of South Africa (CANSA), show LCa is among the top three cancers in men in the country. In women, LCa is ranked seventh. According to CANSA, South Africans' awareness of LCa is severely lacking. As a result, >66% of patients are diagnosed at a late stage when the disease has metastasised.[4]

Signs and symptoms of lung cancer

In their study, Prado et al (2023) identified seven key symptoms and signs associated with a significantly high risk of LCa, which were present at least six months prior to diagnoses.[5]

Types of lung cancer

There are two main types of LCa: Non-small cell lung cancer (NSCLC, 80%-85%) and small cell lung cancer (15%-20%). The predominant subtypes of NSCLC include:[6]

Adenocarcinoma, which usually originates in peripheral lung tissue, and squamous cell carcinoma, which usually starts near a central bronchus.

7 signs and symptoms of lung cancer ..... continue to page 31

Causes of lung cancer

A 2022 study conducted in KwaZulu-Natal by Mbeje et al, shows that apart from tobacco smoking and exposure to passive smoke, alcohol consumption, increased exposure to occupational (eg exposure to silica, arsenic, chromium, cadmium nickel, and environmental carcinogenic substances (eg outdoor air pollution, domestic fuel smoke [wood burning], as well as a history of lung diseases (eg chronic obstructive pulmonary disease), and genetic factors (5.8% of patients present with germline mutations in hereditary cancer genes) are statistically significantly associated with the development of LCa. ③'⑥

A study by Alexandrov et al shows that tobacco smoking is not only associated with the development of LCa, but at least 16 other types including cancers of the larynx, pharynx, oral, oesophageal, bladder, liver, cervix, kidneys, and pancreas. ⑦' ⑧

Furthermore, their study shows a direct link between the number of cigarettes smoked in a lifetime and the number of mutations in tumour DNA. The researchers found that, on average, smoking a packet of cigarettes a day leads to: ⑧

- 150 mutations in each lung cell every year
- 97 in the larynx or voice box
- 23 in the mouth
- 18 in the bladder
- six in the liver.

According to the researchers, the more mutations there are, the higher the chance that these will occur in key cancer genes, which convert a normal cell into a cancer cell. Simply put: The more you smoke, the greater your risk of developing LCa. ⑧

Bracken-Clarke et al caution that vaping and E-cigarettes also increase the risk of LCa – especially in younger patients. Vaping devices and E-cigarettes contain fluids that are either definite or probable oncogenes (eg nicotine derivatives [nitrosnornicotine, nitrosamine ketone], polycyclic aromatic hydrocarbons, heavy metals [including organometal compounds] and aldehydes/other complex organic compounds). ⑨

It is important to note that even never-smokers can also develop LCa. It is estimated that LCa in never-smokers accounts for 10%-25% of cases, and its incidence is increasing, although the reasons remain unclear. ③

What's new in the management of patients with NSCLC?

According to the American National Cancer Institute (NCI), treatment decisions should be based on some of the following: ⑩

- The histological type
- Tumour size and location
- Involvement of pleura
- Surgical margins
- Status and location of lymph nodes by station
- Tumour grade
- Lymphovascular invasion (indicates the presence or absence of tumour cells in lymphatic channels [not lymph nodes] or blood vessels within the primary tumour).

Surgery is potentially the most curative primary therapeutic option for LCa, but according to Souza et al, a small number of LCa patients are eligible for surgery because the majority (~75%) present with locally advanced or distant metastatic disease at diagnosis. ⑥' ⑩

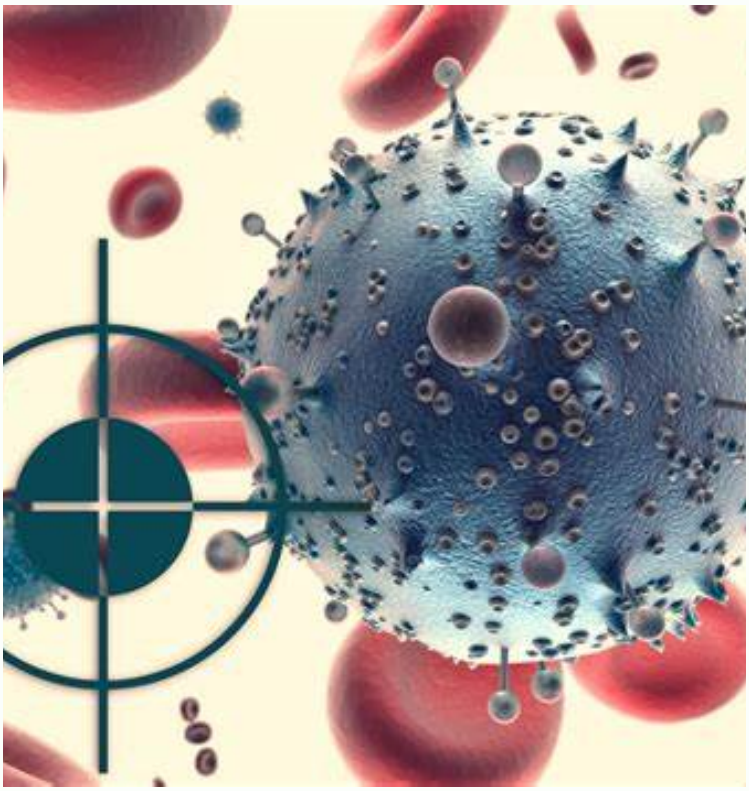
Systemic therapy for cancer consists of anti-cancer agents administered into the system to damage or destroy cancer cells and hence cancer growth, which can be either molecularly targeted therapy, biological therapy such as immunotherapy, or chemotherapy (ChT). ⑪

7 signs and symptoms of lung cancer ..... continue to page 32

Historically, treatment of advanced LCa was limited to ChT. However, the identification of oncogenic driver mutations in NSCLC has dramatically changed the therapeutic approaches over the past few decades (see table 1).[6]

Targeted therapy, directed at the products of oncogenic driver mutations, and immunotherapy, using immune checkpoint inhibitors (ICIs), which facilitates the recognition of cancer as foreign by the host immune system, stimulates the immune system and alleviates the inhibition that allows the growth and spread of cancer cells, has been shown to significantly improve the overall survival (OS) of patients with advanced NSCLC.[6, 12]

In 2015 to 2016, the two-year relative survival for NSCLC was 42% compared to 34% between 2009 and 2010. Between 1990 and 2020, the death rate from LCa dropped by 58% in males, and between 2002 and 2020, the death rate dropped by 36% in females.[14]



New guidelines from the NCCN

The 2023 American National Comprehensive Cancer Network (NCCN) guidelines for the management of NSCLC recommends the following initial treatment in patients with operable disease: Surgical exploration, resection, and mediastinal lymph node dissection or systematic lymph node sampling after pre-operative systemic therapy (if planned).[13]

In patients with inoperable stage N0 disease, radiotherapy, preferably stereotactic ablative radiotherapy, and adjuvant ChT for high-risk stages IB and IIB, followed by surveillance are recommended.[13]

In patients with stage NI disease, chemoradiation, and treatment with durvalumab are recommended for stage III and category 2A stage II disease, again followed by surveillance.[14]

Furthermore, the guidelines recommend that some patients with resectable NSCLC who are likely to receive adjuvant ChT may instead be treated with neoadjuvant systemic therapy after surgical evaluation.[13]

The panel does caution that neoadjuvant therapy should not be used to attempt to induce resectability in patients who do not already meet the criteria for resectability on initial evaluation.[13]

The panel recommends nivolumab platinum-doublet ChT as a neoadjuvant systemic therapy option for eligible patients with resectable (tumours ≥4cm or node-positive) NSCLC and no contraindications to treatment with programmed cell death protein 1 (PD-1) or PD-ligand 1 (PD-L1) inhibitors.[13]

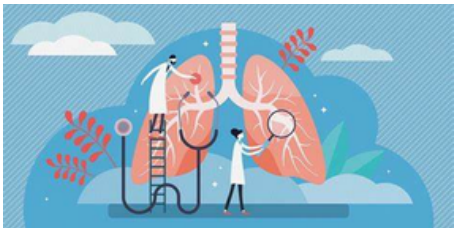
7 signs and symptoms of lung cancer ..... continue to page 33

Contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents, some oncogenic drivers (eg epidermal growth factor receptor [EGFR] exon 19 deletions, EGFR exon 21 L858R mutations, or anaplastic lymphoma kinase gene [ALK] fusions, which occur in ~7% of patients with lung adenocarcinoma) have been shown to be associated with less benefit from PD-1/PD-L1 inhibitors. [6] [13]

EGFR mutations occur in 15%–40% of adenocarcinoma cases. Testing for PD-L1 status, EGFR mutations, and ALK fusions is recommended before administering neoadjuvant nivolumab platinum doublet chemotherapy in eligible patients with stage IB (only T5 4cm) to IIIA and stage IIIB (only T3N2). [6] [13]

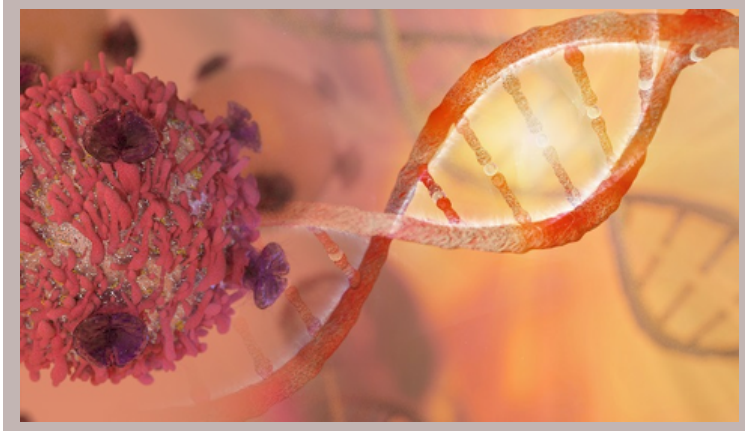
ChT regimens that may be used with neoadjuvant nivolumab include cisplatin either pemetrexed (non-squamous only), gemcitabine (squamous only), paclitaxel (any histology) or carboplatin either pemetrexed (non-squamous only), gemcitabine (squamous only), or paclitaxel (any histology).[13]

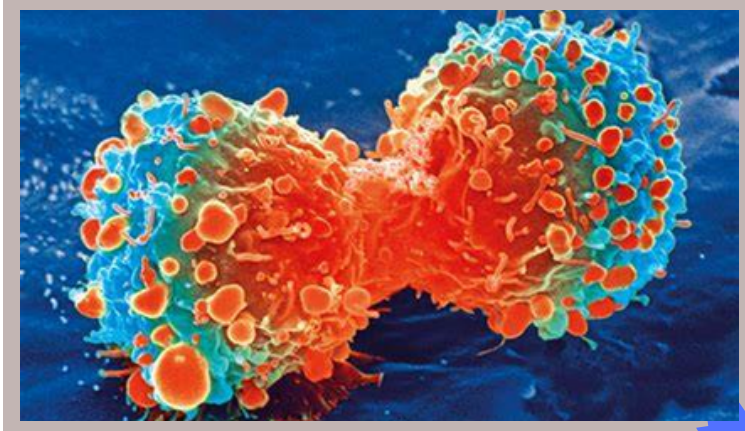
The panel recommends osimertinib as an adjuvant (also known as post-operative) therapy option for eligible patients with completely resected (R0) stage IB (only T5 4cm) to IIIA and stage IIIB (only T3N2) EGFR mutation-positive NSCLC who have previously received adjuvant ChT or are ineligible to receive platinum-based ChT.[13]



The panel recommends atezolizumab as an adjuvant therapy option for eligible patients with PDL1 of ≥1% and completely resected (R0) stage IIB–IIIA, stage IIIB (only T3N2), or high-risk stage IIA NSCLC who are negative for EGFR exon 19 deletions, EGFR exon 21 L858R mutations, or ALK fusions and who have previously received adjuvant ChT or adjuvant pembrolizumab for eligible patients with completely resected (R0) stage IIB–IIIA, stage IIIB (only T3N2), or high-risk stage IIA NSCLC who are negative for EGFR exon 19 deletions, EGFR exon 21 L858R mutations, or ALK fusions and who have previously received adjuvant ChT.[13]

Pembrolizumab should be discontinued for patients with severe or life-threatening pneumonitis and should be withheld or discontinued for other severe or life-threatening immune-mediated adverse events when indicated.[13]





7 signs and symptoms of lung cancer ..... continue to page 34

Table 1: NCI treatment recommendations for patients with NSCLC[10]

Stage (Tumour, node, metastasis definitions)		Treatment Options
Occult NSCLC		Surgery
Stage 0 NSCLC Endobronchial therapies		Surgery
Stages IA and IB NSCLC Adjuvant therapy Radiation therapy		Surgery
Stages IIA and IIB NSCLC Radiation therapy		Surgery with or without adjuvant or neoadjuvant therapy
Stage IIIA NSCLC	Resected or resectable disease	Surgery with neoadjuvant or adjuvant therapy
		Neoadjuvant therapy
		Adjuvant therapy
	Unresectable disease	Chemoradiation therapy
		Radiation therapy
	Superior sulcus tumours	Surgery
		Chemoradiation therapy followed by surgery
		Radiation therapy alone
	Tumours that invade the chest wall	Surgery
		Surgery and radiation therapy
		Radiation therapy alone
		ChT combined with radiation therapy and/or surgery
Stages IIIB and IIIC NSCLC Radiation therapy alone		Sequential or concurrent ChT and radiation therapy
Newly Diagnosed Stage IV, Relapsed, and Recurrent NSCLC Combination ChT with monoclonal antibodies Maintenance therapy after first-line ChT (for patients with stable or responding disease after four cycles of platinum-based combination ChT) EGFR tyrosine kinase inhibitors ALK inhibitors (for patients with ALK translocations) BRAF V600E and mitogen-activated protein (MEK) inhibitors (for patients with BRAF V600E mutations) C-ros oncogene 1 (ROS1) inhibitors (for patients with ROS1 rearrangements) Neurotrophic tyrosine receptor kinase (NTRK) inhibitors (for patients with NTRK fusions) Rearranged during transfection (RET) inhibitors (for patients with RET fusions) Mesenchymal-epithelial transition (MET) inhibitors (for patients with MET exon 14 skipping mutations) ICIs with or without ChT Everolimus (for patients with unresectable, locally advanced or metastatic, progressive, well-differentiated, non-functional, neuroendocrine tumours) Local therapies and special considerations		Cytotoxic combination ChT
Progressive Stage IV, Relapsed, and Recurrent NSCLC EGFR-directed therapy ALK-directed TKIs BRAF V600E and MEK inhibitors (for patients with BRAF V600E mutations) ROS1-directed therapy NTRK inhibitors (for patients with NTRK fusions) RET inhibitors (for patients with RET fusions) MET inhibitors (for patients with MET exon 14 skipping mutations) Kirsten rat sarcoma viral (KRAS) G12C inhibitors (for patients with KRAS G12C mutations) Human epidermal growth factor receptor 2 (HER2)-targeted therapy (for patients with HER2 mutations) Immunotherapy Everolimus (for patients with unresectable, locally advanced or metastatic, progressive, well-differentiated, non-functional, neuroendocrine tumours)		ChT

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Research Casts Doubt on Value of Daily Aspirin for Healthy Adults

Daily use of low-dose aspirin offers no significant protection against stroke and was linked to a higher rate of bleeding in the brain, according to new research.

The research matches other evidence advising that healthy older adults without a history of heart conditions or warning signs of stroke should not take low-dose aspirin.

The findings also support the recommendation from the U.S. Preventive Services Task Force that low-dose aspirin should not be prescribed for preventing a first heart attack or stroke in healthy older adults, The New York Times reported.

"We can be very emphatic that healthy people who are not on aspirin and do not have multiple risk factors should not be starting it now," said Randall Stafford, MD, of Stanford University, who was not involved in the study, in The Times.

It's not as clear for others, he said.

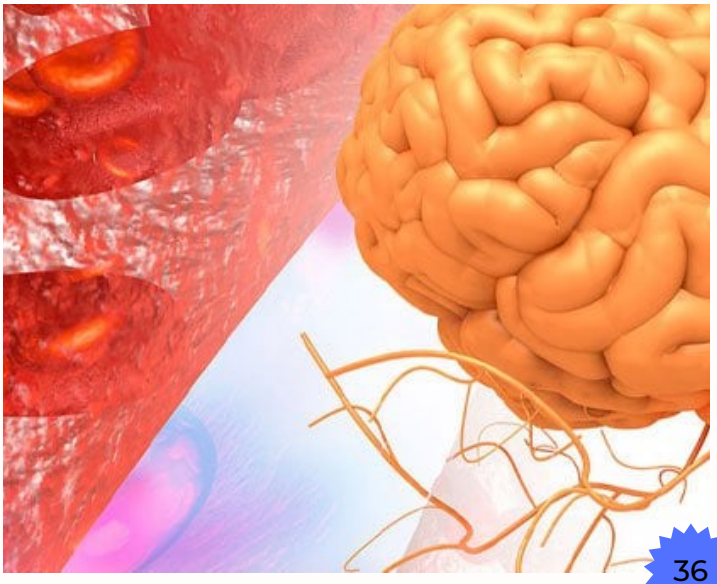
"The longer you've been on aspirin and the more risk factors you have for heart attacks and strokes, the murkier it gets," he said.

Some cardiac and stroke experts say daily aspirin should remain part of the regimen for people who have had a heart attack or stroke.

The JAMA report was based on data from a randomized control trial of 19,000 people from Australia and America. Participants were over the age of 70 and did not have heart disease.

The data covered an average of almost 4.7 years and revealed that aspirin lowered the rate of ischemic stroke but not significantly. An ischemic stroke happens when a clot forms in a blood vessel that sends blood to the brain. There was also a 38% higher rate of brain bleeds for people who took aspirin daily compared to those who took a placebo.

The Times wrote, "In the past, some doctors regarded aspirin as something of a wonder drug, capable of protecting healthy patients against a future heart attack or stroke. But recent studies have shown that the powerful drug has limited protective power among people who have not yet had such an event, and it comes with dangerous side effects."



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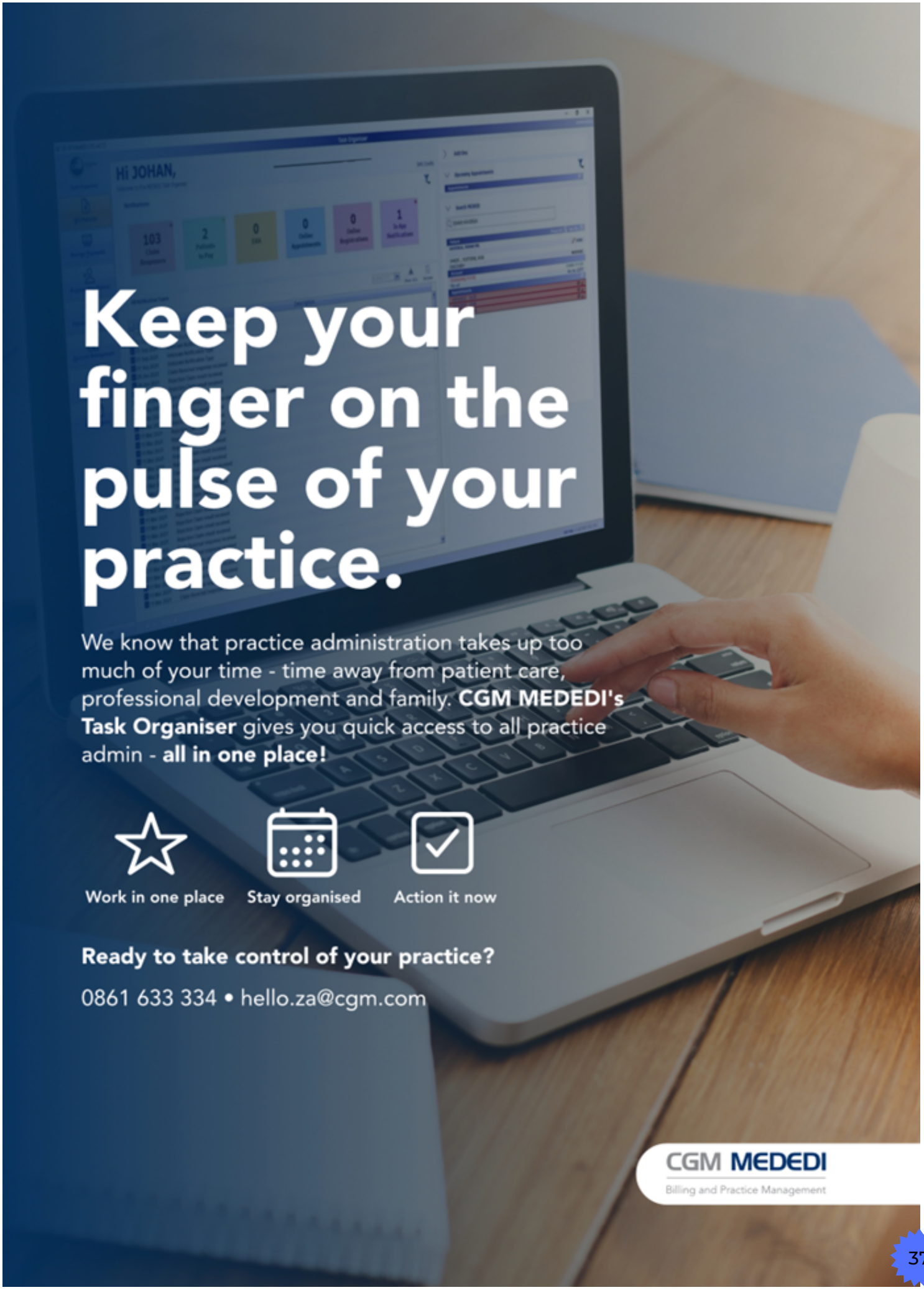
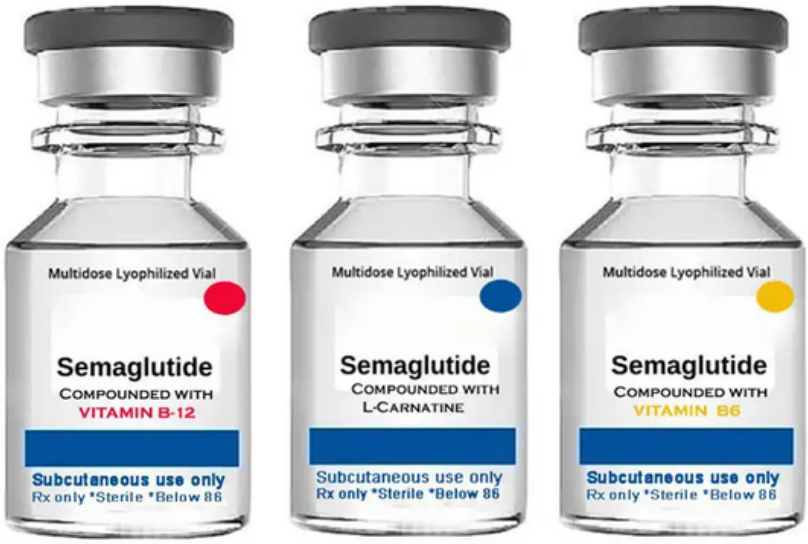


FDA Warns on Certain Forms of Compounded Semaglutide

-some products may not contain the same active ingredient as the approved drugs



Certain compounded forms of semaglutide may not contain the same active ingredient as the approved versions for type 2 diabetes and weight-loss, the FDA warned earlier this weekopens in a new tab or window.

Due to unprecedented demandopens in a new tab or window for the GLP-1 receptor agonist, supply shortages of the injectable forms (Ozempicopens in a new tab or window, Wegovyopens in a new tab or window) have resulted in more and more compounded versions of the drug popping up on the market, and the agency said it has received reports of adverse events associated with these formulations, along with reports of compounders using semaglutide sodium and semaglutide acetate.

These salt forms of semaglutide are different active ingredients than the approved drugs, "which contain the base form of semaglutide," the statement explained.

"Products containing these salts, such as semaglutide sodium and semaglutide acetate, have not been shown to be safe and effective," the FDA said. "Healthcare professionals who are considering working with compounders to obtain semaglutide products should be aware that compounders may be using salt forms of semaglutide. FDA is not aware of any basis for compounding a drug using semaglutide salts that would meet federal requirementsopens in a new tab or window."

No generic form of semaglutide exists, but compounded forms -- a process that involves combining, mixing, or altering ingredients to create the medication -- can be made for individual patients during a shortage. Ongoing demand has landed Ozempic and Wegovy on the FDA's national drug shortage listopens in a new tab or window for the past several months, where they still sit as of May 2023.

The Alliance for Pharmacy Compounding (APC) also recently weighed in on the topic, noting in a statementopens in a new tab or window that semaglutide sodium "does not appear to meet the criteria for compounding," given that it's not the active pharmaceutical ingredient (API) listed on the reference products' labeling, it does not appear on FDA's bulk compounding list, and it does not have a U.S. Pharmacopeia monograph.

"Until more is known about whether or not semaglutide sodium is an API used in either of the FDA-approved drug products, it is APC's current position that compounding with semaglutide sodium technically is not eligible to be used in a compounded medication," the organization stated.

FDA emphasized that patients with a semaglutide prescription from a licensed medical provider should only obtain the drug "from state-licensed pharmacies or outsourcing facilities registered with FDA."

"Purchasing medicine online from unregulated, unlicensed sources can expose patients to potentially unsafe products that have not undergone appropriate evaluation or approval, or do not meet quality standards," the FDA said. "If you choose to use an online pharmacy, FDA's BeSafeRx campaignopens in a new tab or window resources and tools can assist in making safer, more informed decisions when purchasing prescription medicine online."

END

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WHO DECLARES ASPARTAME A POSSIBLE CARCINOGEN

The International Agency for Research on Cancer (IARC) announced today that it has officially classified the artificial sweetener aspartame as a possible carcinogen.

Although this means aspartame might cause cancer in humans, the Group 2B classification from the IARC means the evidence is "limited." A summary of the working group's evaluation, also published today in Lancet Oncology, explained that the classification was based on data from three studies assessing the link between aspartame intake and primary liver cancer.

Using that evidence, the World Health Organization (WHO) and Food and Agriculture Organization Joint Expert Committee on Food Additives (JECFA) confirmed its existing stance that aspartame consumption of up to 40 mg per kg of body weight per day — the amount found in 9 to 14 diet soft drinks — is safe.

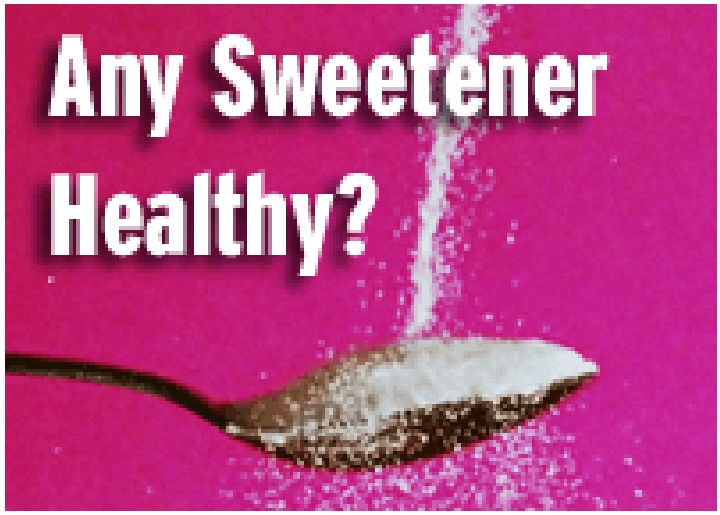
The decision, which was anticipated by Reuters in late June, was met with disagreement from the FDA. On July 14, the FDA issued a statement explaining that the agency "disagrees with IARC's conclusion that these studies support classifying aspartame as a possible carcinogen to humans."

The FDA, which reviewed the evidence included in the IARC's review, explained that "aspartame being labeled by IARC as 'possibly carcinogenic to humans' does not mean that aspartame is actually linked to cancer."

The FDA outlined its safety threshold for aspartame consumption, which is slightly higher than that from WHO and JECFA, at 50 mg per kg of body weight per day, equivalent to 75 packets of the sweetener, Equal.

"Aspartame is one of the most studied food additives in the human food supply. FDA scientists do not have safety concerns when aspartame is used under the approved conditions," the statement read.

An array of experts who weighed in on the study results via the UK-based Science Media Centre also emphasized the safety of aspartame, but suggested that the IARC's decision underscores that.



Many highlighted the lack of data showing a causal relationship between the low-calorie artificial sweetener and sought to temper any alarmism related to the decision.

"In short the evidence that aspartame causes primary liver cancer, or any other cancer in humans, is very weak," said Paul Pharoah, MD, PhD, a professor of cancer epidemiology at Cedars-Sinai Medical Center, Los Angeles, California.

Aspartame a Possible Carcinogen ..... continue to page 41

"Group 2B is a very conservative classification in that almost any evidence of carcinogenicity, however flawed, will put a chemical in that category or above."

Other examples of substances classified as Group 2B are extract of aloe vera, diesel oil, and caffeic acid found in coffee and tea, Pharoah explained, adding that "[t]his is reflected in the view of the [JECFA] who concluded that there was no convincing evidence from experimental animal or human data that aspartame has adverse effects after ingestion."

"The general public should not be worried about the risk of cancer associated with a chemical classed as Group 2B by IARC," he stressed.

Alan Boobis, OBE, PhD, similarly noted that the Group 2B classification "reflects a lack of confidence that the data from experimental animals or from humans is sufficiently convincing to reach a clear conclusion that aspartame is carcinogenic."

"Hence, exposure at current levels would not be anticipated to have any detrimental effects," added Boobis, emeritus professor of toxicology, Imperial College London in England.

The IARC/JECFA opinion is "very welcome"

THE IARC/JECFA OPINION IS "VERY WELCOME" AND "ENDS THE SPECULATION ABOUT THE SAFETY OF ASPARTAME," ADDED GUNTER KUHNLE, A PROFESSOR OF NUTRITION AND FOOD SCIENCE AT THE UNIVERSITY OF READING IN ENGLAND.

"It is unfortunate that leaking some information might have created unnecessary uncertainty and concern as consumers might be rightfully worried if they are told that something that is in many foods could cause cancer," Kuhnle said. "The published opinion puts this into perspective and makes it very clear that there is no cause for concern when consumed at the current amounts."

The data reviewed by the IARC Working Group included three studies, comprising four prospective cohorts, that "assessed the association of artificially sweetened beverage consumption with liver cancer risk," the group reported in The Lancet.

The cohort studies — including one conducted within 10 European countries, one that pooled data from two large US cohorts, and a prospective study also conducted in the US — each "showed positive associations between artificially sweetened beverage consumption and cancer incidence or cancer mortality" in the overall study population or in relevant subgroups.

Although the studies were of "high quality and controlled for many potential confounders," the Working Group concluded that "chance, bias, or confounding could not be ruled out with reasonable confidence." Thus, the evidence for cancer in humans was deemed "limited" for hepatocellular carcinoma and "inadequate" for other cancer types," the group explained.

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WARNING OVER WHATSAPP VOICE NOTES IN SOUTH AFRICA

Technology experts urge caution over WhatApp voice notes amid a rise in cybercriminals using generative artificial intelligence to clone the voices of individuals – especially high-level executives.

The uptake and uses for artificial intelligence (AI) have exploded over the past couple of years and have become a catalyst for change, introducing new ways of doing business, managing data, gathering insights, and collating content.

As an intelligent and highly capable technology, it has become a powerful tool in the business toolbox, providing fast analysis, support, and functionality.

However, it also presents a new and concerning threat as criminals find new ways to use these advancements to their advantage and have harnessed AI for malicious purposes, such as creating convincing deep fakes and perpetrating unnervingly realistic voice scams.

Using artificial intelligence tools to clone voices has introduced an entirely novel realm of risk for both companies and individuals, noted Stephen Osler, Co-Founder and Business Development Director at Nclose.

In 2019, the technology was used to impersonate the voice of the CEO of an energy company in the UK to extort $243,000 (R4.3 million). In 2021, a company in Hong Kong was defrauded of $35 million (R631 million).

These attacks are not just aimed at large corporates; individuals are also now being targeted, Osler said.

Voice clone scams, such as kidnapping hoaxes, requests for money from friends or family, and emergency calls, are all part of these scams that are proving difficult to detect.

Osler warned that WhatsApp voice notes could become a notable vulnerability for people, especially high-level executives.

“Using readily available tools online, scammers can create realistic conversations that mimic the voice of a specific individual using just a few seconds of recorded audio.

“While they have already targeted individuals making purchases on platforms like Gumtree or Bob Shop, as well as engaged in fake kidnapping scams, they are now expanding their operations to target high-level executives with C-Suite scams,” he said.

END

Corner - MARARA Pharmaceuticals complaints

The following compilation has been collected from various Qualicare doctors whose patients have experienced difficulties in obtaining a smooth flow of chronic medication since Marara Pharmaceuticals was included providentially for various Gem options. The information below was obtained from the results of a survey which was published in the last Qualicare newsletter. The information below has been passed on to GEMS management and is reproduced for your attention, and comments. Gems has been offered the right of reply in our newsletter.

Dr in Ceres
Dankie. Ek het dit verkeerd om gehoor.
Die korrekte weergawe is dus dat al die Emerald opsies by Medilogistics bly maar die ander (Dus Ruby en Onyx, Beryl en Saphire) na Marara Pharmacy gaan. Snaaks dat niemand nog enige iets opgetel het nie? Dit is ook snaaks dat GEMS of die Marara apteek - wie hulle ook al is, nie ook kennisgewings uitgestuur het nie? Is die aanbeveling dus dat mens alle herhaal voorskrifte direk na Gems self stuur en hulle dit dan aan die apteek sentrums stuur? - dit lyk beslis vir my na die eenvoudigste opsie.
Groete, Dr >>>>

Dr in Klapmuts
Probleme met chroniese medikasie (Gems pasiënte) -
GEMS: Emerald Value Option: The supplier of medicine can no longer be Medipost (??)
Dian, die vlg. praktyk wat GEWELDIG sukkel met hul GEMS pasiënte se aflewering via Marara (?)
1 dame het nou nog nie haar lewensbelangrike medikasie nie!

Dr in Porterville
Probleme met chroniese medikasie (Gems pasiënte) -
Nog ‘n pr. met klagtes oor GEMS pasiënte se chroniese medikasie: pasiënte se aflewering via Medipos SUKKEL

Al hoe meer pr’e het stadig maar seker begin agterkom dat daar fout is & begin kla oor hul GEMS pasiënte wat nie noodsaaklike CHRONIESE medikasie kry nie? Geweldige ontwrigtende effekte vir pasiënte wat op chroniese medikasie is! (Diabete, hipertensie pasiënte, HIV!!)

Dr in Kraaifontein
Ons pasiente kry nou hulle voorskrifte by apteke

Dr in Kraaifontein
Het vreeslik baie probleme met Gems se apteek vandat Marara oorgevat het by Medipost. Ons het ook vreeslik baie probleme met Pharmacy Direct. Ek het nog nooit so gesukkel met apteke wat nie die voorskrifte “ontvang” nie. Jy is welkom om ‘n paar van ons patiente te kontak wat probleme het.

Dr in Caledon
Ons het oneindig probleme. Eerstens het niemand ons in kennis gestel van die verandering nie. Eers toe pasiente begin kla dat hul nie medikasie kry nadat ons maande tevore die voorskrifte gestuur het, het ons te hore gekom van die verandering. Tweedens jy kom net nooit by hulle uit om 'n navraag te doen nie. Jy skakel deur die regte kanale en wanneer hulle die oproepe deursit, antwoord niemand ooit nie. Verder, as ons 2 0f wat dae later navraag doen om t hoor of die voorskrifte ontvang is, kan hul jou nie 'n antwoord gee nie,want blykbaar kom die voorskrifte nie direk by hulle uit nie, maar gaan nog via Gems se chroniese kanale. Verder se hulle net dat die afleweringsdata het nie deurgetrek het van Medipost nie. As hulle dan die voorskrifte ontvang, le dit net daar totdat iemand eendag navraag doen en die afleweringsdata kan bevestig. Dit is uiters frustrerend en pasiente verstaan nie dat ons nie beheer het daaroor nie.
Dit is veral sleg vir die HIV pasient.

Dr in Caledon
SUKKEL VERSKRIKLIK! Veral ons diabete, hipertensie & HV pasiente! Wie gaan instaan daarvoor as iemand bv. ‘n beroerte kry of so? HIV-onderbreking: so goed jy moet weer van voor af begin!!Stuur voorslkriftein na GEMS; kry verw. nr., MAAR daarna gebeur NIKS! Gee nou maar vir pt. voorskrif om by aptreek te kry (kom dan van hul dag tot dag af!) Dr EN pasient aan verloorkant!

Dr in Gordonsbaai
Ja ons het inderdaad baie probleme ondervind met die Marara groep. Soveel so dat, soos jy noem, pasiente sonder medikasie gelaat is. Ontvangsdame Anne-Mari hanteer hierdie deel van ons voorskrifte. Die probleme was so erg (kon glad nie deurkom na Marara nie) & het uit moedeloosheid maar pasiente gevra om self te skakel, ons het nie die tyd om met hulle (GEMS of Marara) te sukkel nie.

MARARA Pharmaceuticals ..... continue to page 46

gems Corner - MARARA Pharmaceuticals complaints

Dr in Kraaifontein
Ons het en ondervind nog altyd probleme met die nuwe aflewering en ons is nou op die stadium waar ons die pasiente moet apteek toe verwys om die volgende redes: Ons het geen direkte kontak met die nuwe aflewerings dienste nie. Ons moet deur Medipost werk en ons sukkel om deur te kom. Vra ons hulle om terug te bel word dit ook nie gedoen nie. Kry ons iemand in is die antwoord altyd dat hulle nie die voorskrif gekry het nie, maar sodra ons dit stuur kry ons n verwysings nommer. Niemand kom met n oplossing na vore nie en beloftes wat aflewering betref word nie na gekom nie.

Dr in Gansbaai
Ons sukkel geweldig met aflewerings met die pasiënte se medikasie, Mej Viljoen se medikasie is nou al meer as n maand uitstaande. Sy is nou al woedend verby.

Dr in Vredendal
Ons GEMS pt'e ondervind baie probleme om hul chroniese medikasie te kry, sodat hul verplig was om dit by plaaslike apteke kry. Wanneer ons chroniese voorskrifte na GEMS stuur, wag ons gewoonlik tot hul vir ons 'n ref.nr terugstuur en verskaf dit dan aan die pasiënt as hul wil navraag doen. Die pasiënte sê egter dat hul geweldig sukkel om telefonies by GEMS uit te kom om navraag te doen.
Die probleme het geensins intussen verbeter nie.

Dr in Lambertsbaai
Ons het die verandering ook intens hier beleef. Die pasiënte het by die praktyk kom navraag doen, waarom niks ontvang word nie?? Die Medipost verteenwoordiger het later met ons gedeel dat dié nuwe beleid gevolg word. (GEEN inligting oor die veranderinge is vanaf GEMS ontvang nie)
Die probleem was egter meer, wat om met die pasiënt sonder kroniese medikasie te doen. Watter raad gee ons. Reik jy uit, of stuur jy hom onverrigte sake apteek toe, nadat daar weer 'n Rx berei moes word sodat hy gehelp kan word. Die ander probleem is, hoeveel is nou reeds geeis en waar laat dit die patient se magtigings? Waar dit nodig was, het die praktyk die pasiënt verwys na die plaaslike apteek sodat die probleem onmiddellik uitgesorteer kon word.

Dr in Wellington
Ek het GEMS Onyx pasiënte gehad wat ook maande sonder medikasie was – na ek met Medipost kontak gemaak het, was ek meegedeel dat GEMS "oornag" Medipost se diens beëindig het.
Daar was baie probleme aanvanklik met die nuwe apteek se aflewering en ek moes die meeste van my pasiënte na plaaslike apteke verwys om die probleem van medikasie wat nie afgelewer word, op te los. Hulle moes dan ook chroniese apteek (DSP) verander by GEMS.

Dr in Portenville
Daar het weens die probleme baie pasiente migreer na ander apteke. Maande sonder pille: Ja.
Dit is wel beter - maar steeds nie betyds nie. Epos werk en gee 'ref' boodskap.
Pasiente frustrasie - dit reflekteer swak op die praktyk - pasiente vereis hulle kliniese rekords en wil ander dokters gaan sien wat "probleem met aflewering" kan uitsorteer.

Dr in Grabouw
enorme /major probleme - pste sit en wag met ????? geen kommunikasie - veral diabeet/hipertensie / en ons hiv etc - en as ons hul intussen wil help met medikasie hetsy by ons en of plaaslike apteek sal dit uit hul eie sakke moet verhaal word - die kostes ???/
dokters in platteland is ook afhanklike van apteke in hul dorp wat nie altyd n clicks is nie bv jou polmed lede monitor van ons pste op sekere meds - ens raak amper onmoontlik
ons kan nog aangaan met legio goed wat net nie in plek val nie
kostes van praktyke loop die hemele in - nie n share call no nie - en tydrowend en ons gaan regtig uit ons pad om pste te probeer help.

Dr in Lotus River
GEMS Adherence Report Query: for Consultation and Procedure Codes its shows 244 / 0,0% / Non-Adherent. Wanted to know why I queried this with Dr Delport – got out of office, copied Nigel into the email and sent an email to Rammoelo and await a reply from either of them .

MARARA Pharmaceuticals ..... continue to page 47

gems Corner - MARARA Pharmaceuticals complaints

Dr in Kuilsriver
Yes we are having endless problems with Marara Pharmacy.
Patients are complaining that they run out of medication.

Dr in Grassy Park
GEMS Marara: yes, big time problems.. pts not getting full amount of meds, some meds omitted, many are opting to stop use\ing the courier.

Dr in Retreat
GEMS Marara Pharmacy problems encountered:
Yes, we have a patient receiving medication mixed up between husband and wife.

Dr in Vrijzee
MARARA – They are a pain – One of her patients is still waiting on their meds & she has no meds
The other guy eventually got his meds... after so many attempts in contacting them. They are actually pathetic in service delivery.
Is there an email address where doctor can complain about the service from Marara?
One of her patients who has Epilepsy, is still waiting on her Medication. She has no meds.

Dr in Ruyterwacht
MARARA – Yes, 2 of his patients were waiting for their chronic meds. He emailed the script 3 times to Medipost and no response. Receptionist called Medipost & only then found out that they no longer dispense the meds. The one patient went directly to Medscheme in Town to go and query this.

Dr in Mitchells Plain
MARARA - Receptionist – bad service, extremely bad
Receptionist told doctor that today alone - 3 patients whose meds was not delivered. Prior to this he had many patients who complained. He doesn't know what Gems is going to do regarding these chronic patients as they MUST have meds - diabetes, HBP, cholesterol. etc
Medipost – was no problems, but as soon as this Marara took over – ENDLESS PROBLEMS

Dr in Mitchells Plain
MARARA- She actually had 1 patient this year who said his wife get her meds but he never got his. She then had to reissue a script for him

Dr in Rylands
MARARA – Yes she has a few chronic patients with this problem – she advised them to log a complaint with GEMS. One patient got the wrong meds twice – pathetic service

Dr in Athlone
MARARA - Yes her GEMS patients are having problems with medication delivery. Some of them have elected to pick up meds at pharmacy as they were running short

Dr in Plattekloof
MARARA – Yes, a few patients have complained to her- they either don't get their chronic meds or they get delivered late.
The previous supplier's service was bad, but not as bad as this new company.
It seems there are still hiccups with GEMS & patients are really struggling to get their meds on time.

Dr in Mowbray
MARARA -One patient - It's because they changed the email for gems value. It has a different email address & not Medipost anymore, only for emerald value.

Bellville
Doctor said that she has moved all her family and friends to Clicks.
The chronic service of Gems is pathetic and get nowhere with your enquiries and complaints.

MARARA Pharmaceuticals ..... continue to page 48

gems Corner - MARARA Pharmaceuticals

Dr in Atlantis
MARARA - Crazy. Apparently they have not informed any of these patients
He has 2 patients who are on the Tanzanite 1 option who usually had their meds delivered by Medipost. They both queried this with Medipost as they did not receive their meds after 2 weeks. Doctor had to call Medipost on their behalf & was told that Marara has taken over & it is their responsibility to deliver the chronic meds.
He called GEMS – apparently if it is for the low-cost option, they have to use Marara
He doesn't know what is happening – TB needs to speak to Pharmacy Direct as well as this is totally insane that patients who MUST have their chronic meds, are suffering like this.
It takes 5 working days to process after he emails them & they don't work weekends.
They take another 5 days to then possibly deliver – which means 2 weeks before the patient gets their meds.

(Eerste River)
MARARA – Had many patients complaining that are not getting their medication. When the practice calls Marara Pharmacy, they get put on hold for more than 30minutes or longer & sometimes the call gets dropped & they have to call back. And then on top of this frustration, the consultants are rude and unprofessional.
According to the members they were not informed regarding the change in dispensing network pharmacy, neither were they (practice) aware that the network pharmacy changed for certain option on Gems. With Medipost they did not experience this problem. Patients received their medication on time.
They would request that their deliveries be transferred back to Medipost

Dr in Athlone
Our patients have been complaining, their meds are late, not receiving,
getting the wrong medication. Running out of meds, forced to buy it in the meantime.
Apparently Medipost is under new management (Marara) and the professionalism lacks in all departments.
Patients are concerned about their health.

Dr in Blue Downs
Doctor said that he had a lot of complaints.
Now he sends the patients to the pharmacy with their scripts.

Dr in Vredenburg
Ons pasiente is baie kwaad omdat die diens van Marara uiters swak is. Ontvangs sit meer op die telefoon na Marara om uit te vind wanneer pasiente hulle medikasie gaan ontvang. Daar is van ons pasiente wat diabetes het wat nie hulle medikasie ontvang nie. Ons het hulle al gedreig en gese dat as die pasiente in n koma gaan agv nie medikasie ontvang gaan ons hulle dagvaar. Ontvangs het al vir hulle gevra moet sy dan elke dag bel om uit te vind van die pasiente se medikasie.
Daar was vanoggend 'n persoon van Gems wat ons besoek het om te hoor of ons enige klagtes het. Alles is aan hom oorgedra.

Dr in Worcester
There's always an issue with this, they email the scripts through to the medical aid and Marara Pharmacy,
But everything is still being delayed.

Dr in Blackheath
Yes, the patients have been complaining a lot told.

NEEM ASB KENNIS VAN DIE VOLGENDE / PLEASE TEKAE NOTE OF THE FOLLOWING:

Indien u Medipost verkies kan u di volgende stappe volg:

- 'n Praktyk kan nou blykbaar e-pos aan: complaints@gems.gov.za stuur
- Noem die probleem, gee die betrokke pasient se Mediese fonds opsie mét die nr. en versoek 'n 'RUIL' ...
- Versoek dat medikasie asb. terugeruil kan word van Marara na Medipost

If you prefer Medipost you can follow these steps:

- A practice can now apparently email to: complaints@gems.gov.za
- Name the problem, give the relevant patient's Medical aid option the no. and request a 'SWAP' ...
- Request that that medication be exchanged from Marara to Medipost.

END

Medscheme CORNER

Q: Dr P in NOT on the Polmed Network, which is a huge frustration! How to go about to 'improve' his consultations to POLMED patients? What topdo & what NOT to do?
A;.....REPLY: Polmed: 'See below on how Dr can improve his profile'.
How to improve your profile
Doing an Annual Medical Examination on members over the age of 21yrs
Using Consultation Code 55500 once a year instead of 0190
Includes the following screening tests:

- Blood Pressure test
- BMI test
- Cholesterol screening
- Glucose screening
- Lipid disorder screening for age over 40yrs
- Occult blood for Peptic ulcer disease
- Risk Assessment tests:
- HIV Screening
- HPV screening
- Mammograms
- Pap smears
- Prostate screening

Registering chronic patient on Disease Risk Management Programmes with Medscheme offers the following advantages:

- Members get additional consultation visits based on the ICD code and it pays from Risk and not Day to Day Benefits
- You can manage the patient in your rooms without having to refer patient to a Specialist for admission.
- You only refer to Specialist when is medically required.
- You will receive a Care Plan which outlines the treatment plan, and you will be given the opportunity to provide input in the Care plan.

Q: THANK YOU ..... – appreciate.
-However, the question has always been: how many of the 'procedures' must be done during such a visit? (55500)
-On the surface, it seems that 'everything' must be done in the 1 examination, which of course is absolutely impossible
-Perhaps the wording should be adjusted to indicate how many procedures should be done as a minimum during a 55500 consultation?
(Dr Behrman has also inquired about it at Polmed, but has NEVER been able to get a satisfactory answer)
-Maybe you could address that? (We would appreciate it, thank you.)

Q: GEMS REPI CAT Dr R Fakier: Query meaning of 244 / 0,0% / Non-Adherent on the GEMS REPI report
A: N.....REPLY: We fixed the error regarding the REPI score and emailed the affected practices an updated report with the correct REPI category

Q: GEMS Marara Meds not received yet: Dr .....
newly diagnosed Diabetic and really needs to be on meds. I've been struggling since June to get him his meds. Every time a different story from Marara.
A: R.....REPLY: The request is acknowledged and has been escalated for assistance.

Medscheme CORNER

Q: Medscheme Contracted or not Dr R Fakier:
A: MERLE REPLY: Contacted Glynnis, advised her that the Medscheme IPA Doctor Network Agreement needs to be completed first. After 48 hours the rest of the annexures will appear.
However, the only contracts Dr has not signed is attached, she is busy completing them now.

Q: Dr L Bhikoo (Panorama)
2 Queries that I forwarded to nc@medscheme.co.za- copied M..... in
P..... – 000000000000
Dr.....- Member Number: 000000000000
Rejections???**?**

Q: Medscheme -Deregister of contracts
Could you please assist PR 0813168 to deregister from these following schemes – see email below?

- AECI
- Bonitas
- Fedhealth
- Samwumed

A: M..... forward to the scheme Medscheme Reply

Dear Healthcare Provider

YOUR REQUEST FOR TERMINATION FROM THE AECI - BONITAS - FEDHEALTH AND SAMWUMED GP NETWORK

We acknowledge your request to terminate your Network Agreement with the AECI - Bonitas - Fedhealth and Samwumed GP Network.

Receipt of your email requesting this termination is also acknowledged.

In accordance with the current contract, the contractual agreement will be duly terminated on 07/10/2023.

Thank you for your past participation in this network.

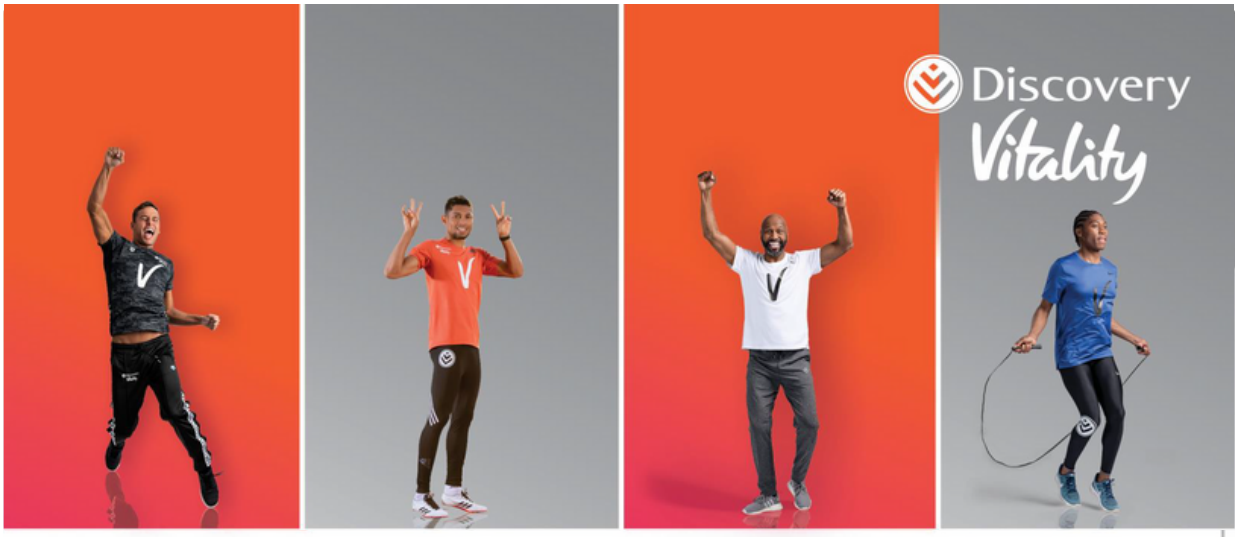
If you have any further queries or should you wish to participate on the Network in the future, you are welcome to do so by contacting us on 086 111 2666 or email us at nc@medscheme.co.za

Yours sincerely

Medscheme Network Contract Management

END

Discovery CORNER



1. What is the difference between a VHC and EVHC?

The Vitality Health Check is now made up of 5 measures (including blood pressure, blood glucose, cholesterol, a weight assessment and signing a non-smokers declaration). The Enhanced Vitality Health Check includes a lipogram test, should a member's readings be out of range. Please see below which plans and schemes are eligible for VHC and EVHC testing.

Vitality Health Check (VHC)	Enhanced Vitality Health Check (EVHC)
Blood pressure	Blood pressure
Blood glucose	Blood glucose
Cholesterol	Cholesterol
Weight Status incl. BMI and waist circumference (BMI)	Weight Status incl. BMI and waist circumference (BMI)
Non Smoker's declaration sign off	Non-Smoker's declaration sign off
	Lipogram

Members can earn up to 22 500 Vitality points when they do their VHC, depending on how many of their results are in a healthy range.

VITALITY HEALTH CHECK RANGES

Metric	Blood Glucose	Blood pressure	Cholesterol*	Weight Assessment**	Smoker status
In-range	< 7.8mmol/L	< 130/80mmHG	< 5mmol/L	18.5 <BMI < 25	Non-smoker for at least the past 12 months
Intermediate risk	7.8mmol/L ≤ blood glucose < 11mmol/L	130/80mmHg ≤ blood pressure < 160/100mmHg	5mmol/L ≤ total cholesterol < 7.5mmol/L	BMI < 18.5 Or 25 ≤ BMI < 30	n/a
High risk	≥ 11mmol/L	≥ 160/100mmHg	≥ 7.5mmol/L	BMI ≥ 30	Smoker

Vitality members 65 years and older have access to the Vitality Health Check for 65+.

VITALITY HEALTH CHECK RANGES 65+					
Metric	Blood Glucose	Blood pressure	Cholesterol*	Weight Assessment**	Smoker status
In-range	< 7.8mmol/L	<140/90 mmHg (in range if both systolic and diastolic are below these thresholds)	< 5mmol/L	18.5 kg/m2 <=BMI<25 kg/m2 **OR** From 25 to 29.9 kg/m2 with waist <88cm for females / <102cm for males	Non-smoker for at least the past 12 months
Intermediate risk	7.8mmol/L ≤ blood glucose < 11mmol/L	140/90mmHg ≤ blood pressure < 159/99mmHg	5mmol/L ≤ total cholesterol < 7.5mmol/L	BMI<18.5 kg/m2 **OR** From 25 to 29.9 kg/m2 with waist ≥88cm for females / ≥102cm for males **OR** BMI ≥30 kg/m2 with waist <88cm for females / <102cm for males	n/a
High risk	≥ 11mmol/L	≥ 160/100mmHg	≥ 7.5mmol/L	≥30 kg/m2 with waist ≥88cm for females / ≥102cm for males	Smoker

Earn Vitality points depending on how healthy you are

In range results	0 high risk results	1 high risk result	2 or more high risk results
5	22 500 pts		
4	15 000 pts	12 500 pts	
3	10 000 pts	7 500 pts	5 000 pts
2	5 000 pts	3 500 pts	2 500 pts
1	2 500 pts	2 500 pts	2 500 pts

Examples:

- If a member has four in-range results and one intermediate-risk result they will earn **15 000 points.**
- If a member has three in-range results and one high-risk result they will earn **7 500 points.**

The member can earn up to 22 500 Vitality points. This means that they can earn up to 25 000 points and reach Silver Vitality status by having all their results in range, finding out their Vitality Age (1500 points) and completing the mental wellbeing assessments (500 points twice a year). Members will only be awarded additional Vitality points if their tests are performed at least **90 days apart**.

The points members will earn for doing an HIV test

The points for HIV screening will be allocated to encourage first-time screening and to reward management of the condition once diagnosed. Members will earn:

- 7 500 Vitality points the first time you go for an HIV test
- 1 000 Vitality points per year, if you have previously earned points for doing an HIV test
- 2 500 points for registration on the HIV Care programme if you are diagnosed

Discovery Vitality

When should you administer a full lipogram test?
A full lipogram test should be recommended or administered if the member has a cholesterol level 5 mmol/l or higher.

How does the Vitality Health Check activate the WELLTHFund?
Once a member (and and their family) have done a Vitality Health Check, they will have access to the WELLTH Fund. The WELLTH Fund is designed to cover a range of important check-ups and other healthcare services that they may want to do following their Health Check. Members do not have to pay for these healthcare services that are covered by the WELLTH Fund. This benefit is available once all members on the membership have completed a Health Check. Members who are 18 years and older can complete a Vitality Health Check and members younger than 18 years can choose to complete either the Kids Vitality Health Check or the online Kids Vitality Health Review.

2. Which plans are eligible?

The Vitality Health Check is offered by various schemes.
*** Members who are on a Discovery Health Administered Scheme, but do not have Vitality can complete the Discovery Health Check which is offered by the following schemes:*

Schemes administered by Discovery Health that cover health checks

705255-001 Traditional VHC applies and paid from Risk	001093-001 EVHC applies and paid from Risk
Anglo Medical Scheme (AMS) Anglovaal Group Medical Scheme Glencore Medical Scheme Malcor Medical Aid Scheme UKZN Medical Scheme	Discovery Health Medical Scheme M-Med Option of the Naspers Medical Fund Tsogo Sun Group Medical Scheme – all options Quantum Medical Aid Society – all options BMW Employee Medical Aid Society TFG Medical Aid Scheme TFG Health LA Health Medical Scheme Remedi Medical Aid Scheme Retail Medical Scheme TFG Health (TFGMAS) TFG Health Plus (TFGMAS) SAB Medical Aid Benefit – all options

3. What are the costs?

What will the Vitality Health Check cost you?
Once you have the necessary equipment, you can offer a VHC/ EVHC in your rooms. You need to be a member of the Vitality Wellness Network to do this, but there is no cost to join the network.

What it will cost your patient:

- The five assessments that make up the VHC are covered at the VHC rate. They are paid from the Risk benefit of most medical schemes administered by Discovery Health (Pty) Ltd, depending on the plan type and benefit rules (*refer to Question 8 for* Claims & Rates).

- Members of most medical schemes administered by Discovery Health (Pty) Ltd, are covered for one Vitality Health Check a year from their Screening and Prevention Benefit – this will not impact the member's day-to-day benefits (If the member is in a general waiting period, the medical scheme does not cover this).
- The lipogram can be done as a standalone test by members who are not eligible for EVHC and will cost the member R199.10 each payable from MSA, subject to available funds.
- Lipogram testing cannot be claimed together with EVHC, as it is included in the EVHC.
- The member can also opt to have an HIV test conducted by you, which is also paid from their Risk benefit. Members of most medical schemes administered by Discovery Health (Pty) Ltd, are covered for one HIV test a year from their Screening and Prevention Benefit – this will not impact the member's day-to-day benefits (If the member is in a general waiting period, the medical scheme does not cover this). Please note that for HIV testing, members will be requested to give consent for the test to be completed, and for the results to be captured and stored by Discovery Limited.
- A Kids Vitality Health Check can also be offered, this is covered from the Risk benefit for members of Discovery Health Medical Scheme and certain other schemes administered by Discovery Health (*refer to Question 8 for Claims & Rates*).

Kids Vitality Health check

- Kids will still be able to complete the assessments, however they will not earn points towards the family status.
- We have introduced Vitality Active Rewards for Kids and Teens, to partner with parents to make kids healthier. Instead of earning Vitality points, this new programme directly rewards children with Discovery Miles for doing relevant health checks and participating in physical activity.
- Children will continue to earn Vitality points towards the family Vitality status for getting vaccinated.

4. Who qualifies to do a VHC / EVHC?

Members over 18 years old can go for a VHC / EVHC.

The Kids Vitality Health Check is available to children between the ages of two and 18 years old. Once a child turns 18, they will need to complete the Vitality Health Check.

5. How do I request for VHC / EVHC Consent?

- You will request that the patient completes the mandatory Vitality assessment consent form.
- The patients' details and signature must be legible and correctly dated according to the completed Vitality assessment date.
- You must store the completed signed consent form in a secure location (either a locked cupboard or locked filing room) for a period of 7 years from the Vitality assessment date.
- Should proof of consent be required for auditing purposes, you will be contacted by Vitality Partner Operations requesting a copy of the signed consent form.
- You should not store any Vitality patient reports on your computers, servers, or any other mechanisms capable of storing such reports, nor shall such reports be used by you without Discovery Vitality's prior approval, as the aforementioned constitutes Discovery Vitality's Intellectual Property.

Discovery Vitality

6. How many VHC's / EVHC's can my patients do a year?

If a member's Vitality Health Check assessment results are out of range, they can take action through lifestyle changes or medication and complete the assessment again later in the year. Vitality points will be awarded based on the best result in the year for each metric. They'll only be awarded additional Vitality points if their tests are done at least 90 days apart. This gives them enough time to address their underlying risk factors and take steps towards improving their results.

One VHC a year is paid from your patient's Risk benefit of certain medical schemes administered by Discovery Health (Pty) Ltd.

If they choose to do more than one Vitality Health Check in a year, it will be funded according to their plan benefits.

7. How do I claim for conducting a VHC / EVHC?

You can claim electronically, as you would for any other consultation or test. Refer to the below table for the claims codes.

8. Which codes do I use to claim for a VHC / EVHC?

Use the codes below to claim:

Assessment	Abbreviation	Code	Rate	Payment
Vitality Health Check	VHC	705255001	R240.50	One per member, per year, paid from Risk benefit of most schemes administered by Discovery Health (Pty) Ltd
Enhanced Vitality Health Check (Includes lipogram)	EVHC	EVHC + ICD10: Z13.9	R273.30	
HIV Voluntary Counselling and Testing	VCT	7000 (pre-counselling) 7010 (post-counselling)	R177.50 R355.50	
Kids Vitality Health Check	KVHC	VKIDS - 001055	R92.30	

9. Standalone tests

Assessment	Abbreviation	Code	Rate	Payment
HBA1C		HBA1C	R199.10	

Full Lipogram (Included in the EVHC)		LGRAM	R199.10 This can only be done by members who are only eligible for VHC. Members who qualify for EVHC should not do this assessment as a Standalone as it is included in the EVHC.	Payable from MSA, subject to available funds
Non Smokers declaration			R39.90 This is a CASH only assessment, it is not claimable from the Medical Aid.	

- * The HbA1c and full Lipogram are payable from MSA and subject to available funds. HbA1c point-of-care remains an acceptable monitoring tool for the diabetic patient.

10. Can I claim for consumables?

The cost of consumables is included in the rate for each of the assessments, as per the above table.

11. How do I submit results?

You can submit your patients' results online on the HP Zone on www.discovery.co.za. Access the HP Zone Navigation guide.

The VHC report must be submitted in real time and the VHC consultation must include the discussion of outcomes from the VHC report. Should you experience a system issue with the generation of the VHC report, please report this to Vitality Partner Operations on 011 529 8898 or email vitalitywellnessnetwork@discovery.co.za

12. How do we calculate Vitality Age?

We look at 8 risk factors when we calculate the Vitality Age in your VHC report:

- Body mass index (BMI)
- Systolic blood pressure
- Diastolic blood pressure
- Fasting blood glucose
- Serum total cholesterol/ LDL
- Smoking
- Dietary behaviour (fruits and vegetable intake)
- Physical activity

Discovery

ative risks for each individual lifestyle and clinical measure are used to calculate a ive risk factor that we use to estimate life expectancy. Vitality Age is then calculated as the difference between standard and adjusted life expectancy.

13. How does the Vitality Age help change behaviour?

Presenting overall health risk as Vitality Age is not only a simple way to help you understand your health risks, but it is also a very effective **behaviour change tool**. When your Vitality Age is higher than your chronological age, it motivates you to change your behaviour and regain your "lost" years.
The Vitality Age model is continuously refined as self-reported data is compared with real outcomes of thousands of members across the various markets in which Vitality operates.

14. Does the member get a report with their VHC / EVHC results?

Yes, we compile and send your patients a report once you capture their results on the HP Zone. This will be emailed to the member as a secure link to access their report on www.discovery.co.za. The member's results (but not the report) are also available on Health ID.

15. Can I recapture results if I make a mistake?

To recapture results, you will need to contact Vitality to reverse the captured results and allow you to recapture the correct results. To do this, please send an email to vitalitywellnessnetwork@discovery.co.za

16. How long does it take for their Vitality points to reflect once I've captured the data?

Vitality points can take between 24 and 48 hours to reflect.

17. Can I claim for a consultation if a member comes in only for a VHC / EVHC?

No, if your patient just comes for a VHC/ EVHC, you cannot claim for a consultation too.

18. Can I advertise the VHC / EVHC and what are the branding guidelines?

Yes, you can advertise that you offer these services. Check the Discovery Vitality brand guidelines for what is allowed and send all artwork to Vitality Wellness Network for approval.

19. Who do I contact for support?

If you have a technical issue, please call web support on 0860 100 696 or email webinfo@discovery.co.za

If you have a non-technical concern or query, please call Partner Services on 011 529 8898 or email vitalitywellnessnetwork@discovery.co.za

20. Who do I contact if I want to leave the Vitality Wellness Network?

If you wish to leave the network, email the Vitality Wellness Network on vitalitywellnessnetwork@discovery.co.za and request to be removed.

21. Can a KeyCare patient see a non-network KeyCare doctor to do a VHC / EVHC?

Yes, the patients can see a non-network provider, it is not subject to their primary or secondary doctor.

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-ember 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 R7000.00 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 have additional benefits for a NEW MEMBER / **FIRST-TIME PRACTITIONER.**

Should you be interested in this offering, please email Louna at pa@cpcqualicare.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

Qualicare Electronic Doctor Network.
A free gift (valued at R7,500.00 per year) only for 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 R7500.00 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: _____

Qualicare EDN ..... continue to page 61

Qualicare EDN ..... continue from page 60

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.

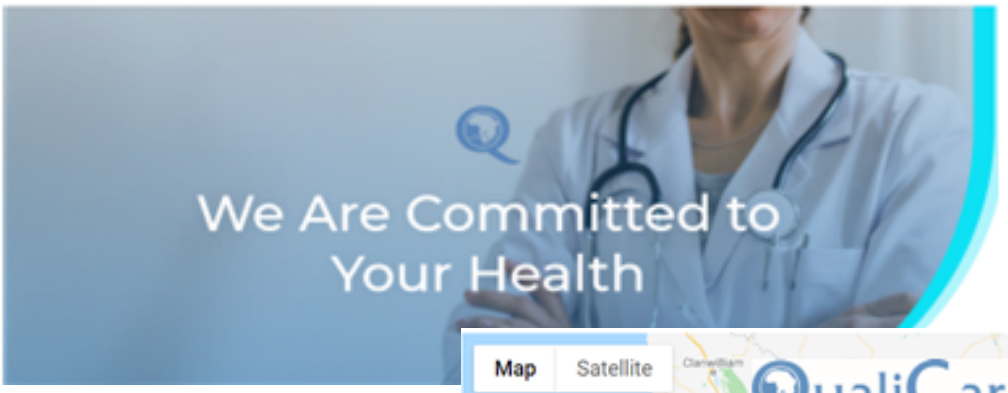
Please feel free to contact Annerè van Pletsen CPC/Qualicare Consultant at annere@cpcqualicare.co.za

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/



Summary					
Reported period	Month Jun 2023				
First visit	01 Jun 2023 - 00:12				
Last visit	28 Jun 2023 - 00:53				
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	**1,417**	**1,727** (1.21 visits/visitor)	**4,809** (2.78 Pages/Visit)	**37,416** (21.66 Hits/Visit)	**4.60 GB** (2791.32 KB/Visit)
Not viewed traffic *			**18,046**	**48,938**	**2.64 GB**

* Not viewed traffic includes traffic generated by robots, worms, or replies with special HTTP status codes.

www.docweb.co.za

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www.qualicaredoctors.co.za

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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