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Newsletter

The Certificate of Need will empower the Minister of Health to regulate health establishments and health-care providers and their conduct.

The Certificate of Need

The true colours regarding the Certificate of Need are finally coming into focus with a comment made by National Department of Health spokesperson Foster Mohale, who was commenting on allegations of manipulation of billing by a leading hospital grouping.

"While this is clearly of concern in that reimbursements were potentially manipulated to achieve a particular objective, the department is not in a position to undertake any form of investigation regarding the said allegations."

"The reason for this is that private hospitals remain relatively unregulated, except with regards to the licensing processes that are the purview of the provincial departments of health." he said.

In relations to the **Certificate of Need** he said:

"The Department of Health is finalising the regulations operationalising Section 36 to Section 40 of the National Health Act, in relation to **Certificate of Need**.

The Certificate of Need ....continue to page 2

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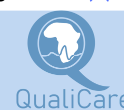

As per the recommendation of the Health Market Inquiry, these regulations will empower the minister of health to **regulate health establishments and health-care providers and their conduct."**

Empower the minister of health to regulate health establishments and health-care providers and their conduct.

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Office of Health Standards Compliance: (OHSC)

A further word of caution extends to the request by the Office of Health Standards Compliance to local GPs in the various provinces to attend meetings discussing future inspections of private practices in the Western Cape in preparation for the delivery of Primary Health care services through contracting units referred to as "CUPs."

You will recall that CPC/Qualicare regularly publishes a checklist for our shareholders and members to evaluate their practice facilities according to international guidelines which were put together for the South African Medical Contracted Community (SAMCC) by Professor Morgan Chetty of the KZN University Medical school.

I am confident that many of our longstanding as well as newer shareholders and members have completed this checklist on an annual basis and therefore have little need to meet with the Office of Health Standards Compliance as the document which they developed, originated along very similar lines to the one which we are already using.

There however may be a second agenda to the OHSC meetings, and that could be to ascertain which GP practices may be suitable for delivery of primary care to future NHI patients.

If this is the case, why have they not come out into the open and declared that is what they are looking for? Why too, do they not know what the capitation rate will be which the NHI will offer the GPs to look after the patients allocated to them? Or if they do not know, how can they hold such a meeting looking for compliant practices which may not be in a position to accept a non-market related capitation rate?

Listing OHSC approved practices could be seen as a form of indirect coercion, which could be used, if it got into the wrong hands, to pressurise GPs to accept an unrealistic capitation offering from the NHI.

This , coupled with the Certificate of Need , which threatens the practice with the Sword of Damocles, should he/she be practicing in an area which the CON deems "overserved with doctors" unless he complies with their NHI recommendations , and you are right bang slap into soviet styled coercive medicine ☹

To be totally clear :

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EVERY SHOUTH AFRICAN SHOULD BE ENTITLED TO FULL ACCESS FORTHEIR HEALTHCARE NEEDS.

We however do NOT believe that NHI is the way to achieve this.

QC Team

Business groups drop NHI tax bombshell!!

Organised business has sounded a warning about the feasibility of National Health Insurance (NHI), saying the huge tax increases required by the government's plan are unaffordable.

The government's estimate that it will need to raise an extra R200bn in tax revenue to finance NHI would require increasing personal income tax by almost one-third, VAT from 15% to 21% or applying a payroll tax that is 10 times higher than the current UIF contribution, or a combination of these three increases, Business Unity SA (Busa) and Business for SA (B4SA) said in a joint statement.

"This is obviously unworkable as SA taxpayers are already under extreme financial pressure and any increases are bound to impact them materially," they said.

Busa represents organised business interests, while B4SA is an alliance of business leaders that works with the government on problems confronting SA.

The tax impact analysis was provided by FTI Consulting.

NHI tax bombshell .... continue to page 4

NHI is the government's controversial plan for reforming SA's healthcare system to achieve universal coverage. It aims to create a single health service for all citizens that is free at the point of delivery, built on social solidarity principles in which the rich and healthy subsidise the poor and sick.

The first piece of enabling legislation for the plan, the NHI Bill, was passed by the National Assembly in June and is now under consideration by the National Council of Provinces.

The bill proposes establishing a central NHI fund that will pool funds to purchase services from accredited public and private providers for all eligible patients. One of its most contentious aspects is the sharply diminished role of medical schemes, which will only be allowed to offer "complementary cover" for services not provided by the scheme once it is fully implemented.

Organised business said it supports the concept of universal health coverage, as healthy populations are more productive and can participate more meaningfully in the economy, but it does not support the single purchaser model set out in the bill.

"The NHI Bill's single funder model, where government is the only source of funding and procurement for all health services, poses a significant risk to the economy. It introduces serious systemic risks associated with governance, the country's ability to attract and retain skills and investment, the removal of competition in buying health services and the feasibility of raising taxes," it said.

"It is imperative that we get the NHI model right before it is adopted into law as there are severe ramifications and unintended consequences for passing and subsequently implementing legislation that is not fit for purpose."

Busa previously appealed to the government to let medical schemes continue under NHI,

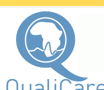
arguing that this will ensure the private sector remains viable and reduce the load on public health facilities.

At SA's second presidential health summit in May, it proposed that section 33 of the bill be amended to allow a multipurchaser model. That appeal fell on deaf ears, but B4SA chair Martin Kingston said there is still scope for this aspect of the bill to be amended by the National Council of Provinces.

"There is a heightened awareness of the contradictions that exist in the proposed legislation and a keen interest among all stakeholders, including government, in seeing how there can be a realistic and pragmatic approach to universal health coverage based on a model that is implementable," he said.

Economic circumstances have worsened significantly since the bill was drafted, he said, noting that the Treasury is expected to signal further budget cuts in October.

Business has demonstrated it can play a powerful role in tackling some of SA's most pressing problems. The private sector has immense resources and capabilities that could be tapped into to improve the delivery of healthcare, but not in the manner proposed in the NHI Bill, Kingston said. "We don't think collapsing everything into the structure that is being postulated is appropriate."



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Mediclinic's alleged manipulated costs raise concerns

Photo by Gallo Images/Misha Jordaan

The National Department of Health said it noted with concern allegations of patient bill manipulation at private hospital group Mediclinic, but said it was not in a position to investigate private hospitals as they remained relatively unregulated

This while it engaged with the Council for Medical Schemes to direct regulated medical schemes to investigate.

In an email from an anonymous source, the person identifying themselves as a whistleblower said they worked as a clinical case manager and coder, and alleged that at the hospitals, patients' conditions were manipulated to either bill at an ARM (alternative reimbursement model), or coding was used to "carve an account out" to bill for services where the loss would be too significant for the hospital.

"Case managers are also expected to 'open' in-hospital accounts for patients who died in the emergency room, and these accounts are mostly ICU accounts because of the high cost of resuscitation medication, and were moved from the emergency room account to the 'hospital ICU account' because the fixed fee for these high cost incidents again resulted in higher losses for the hospital," the source said.

"Glad to see you maintaining an arm's length relationship with your client."

Mediclinic's alleged manipulated costs .... continue to page 6

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They detailed incidents at six hospitals in the Western Cape and Gauteng.

At Mediclinic Cape Gate, they alleged high-cost emergency unit medication was transferred to the in-hospital account for admitted patients to prevent the emergency unit from being "a cost centre".

At Mediclinic Vergelegen, its alleged that an in-hospital ICU claim was opened for patients who died in the emergency unit.

The whistle-blower said they resigned because they felt the company was not living up to its ethics, and were afraid that if this was raised, they would be victimised.

Mediclinic said it had commissioned an independent audit by an external expert to review the accusations.

"Mediclinic views these accusations in a severe light as they affect vital relationships with health-care funders and patients. Mediclinic prides itself on applying uncompromised ethical practices throughout every aspect of its entire business and is proud of its reputation as a values-driven hospital group providing care that one can trust.

"Mediclinic is confident that the audit will confirm that its billing processes are accurate and ethical. However, should the external experts find any accusations to be true, Mediclinic will not hesitate to act decisively and appropriately on the findings," the hospital group said.

National Department of Health spokesperson Foster Mohale said:

"While this is clearly of concern in that reimbursements were potentially manipulated to achieve a particular objective, the department is not in a position to undertake any form of investigation regarding the said allegations.

"The reason for this is that private hospitals remain relatively unregulated, except with regards to the licensing processes that are the purview of the provincial departments of health.

"The Department of Health is finalising the regulations operationalising Section 36 to Section 40 of the National Health Act, in relation to Certificate of Need. As per the recommendation of the Health Market Inquiry, these regulations will empower the minister of health to regulate health establishments and health-care providers and their conduct.

"Unfortunately, health-care providers have challenged the promulgation of the Certificate of Need and the matter is still in the courts. Medical schemes, regulated by the Council for Medical Schemes, generally have forensic investigation units that focus on looking into such matters.The department is engaging with the council to direct the regulated medical schemes to investigate the allegations. The department recommends that the matter be reported for investigation by the relevant authorities."

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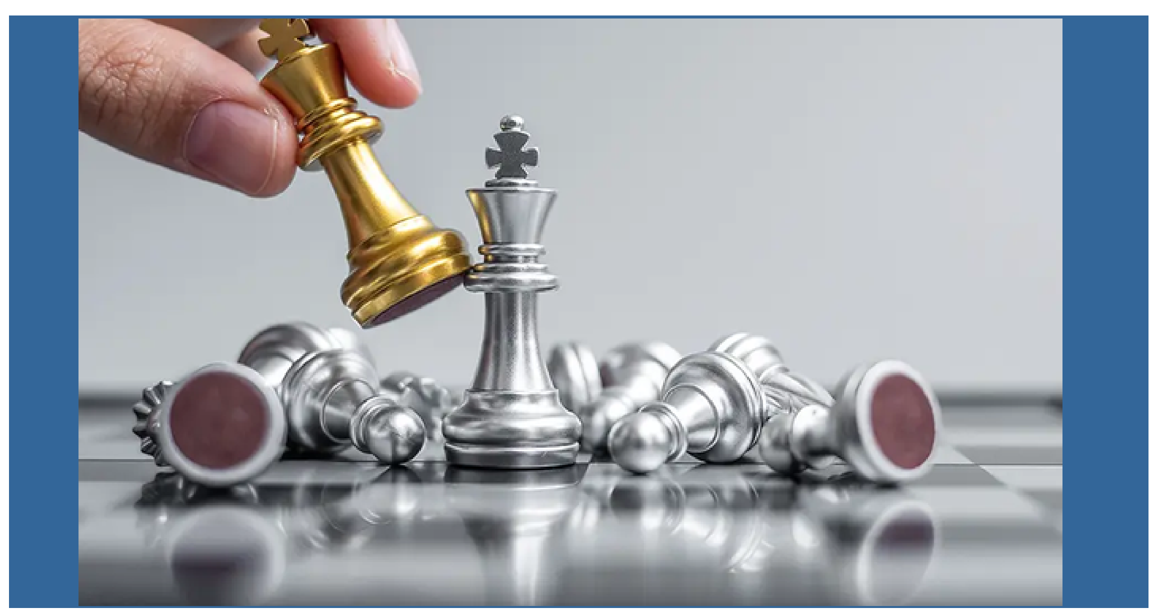
NHI BILL FACES CONSTITUTIONAL CHALLENGES

This article delves into the diverse constitutional qualms that have surfaced following the introduction of the NHI Bill in South Africa.



Provisions of the NHI Bill that grant overweening powers to the Minister of Health could be challenged as unconstitutional, not to mention the fact that the Bill is not consistent with the constitutional rights to equality and human dignity.

An amended version of the NHI Bill was passed by the National Assembly in June and while this version of the Bill did include some amendments, recommendations made by many interested parties, including the private health sector, political parties, trade unions, civil society organisations, legal experts, and others don't seem to have been considered. Concerns raised by the parliamentary legal adviser appeared to be ignored as well.

As a result, the Bill has come under heavy criticism for being unworkable and unconstitutional resulting in a slew of threats of litigation. Legal experts at Weber Wentzel have said that the NHI bill is an over hasty attempt by the government to completely transform public healthcare, leaving confusion and potential destruction in its wake.

LEGAL CONCERNS

"The spectrum of legal concerns is vast," said The Institute of Health Risk Managers' Heidi Kruger. "It includes the constitutionally based concerns, for example, the lack of clarity of the benefits that will be provided by the scheme, because the bill obviously is supposed to progress the States' obligation to realise access to healthcare services in terms of section 27 of the Constitution. And so, without knowing the list of benefits that will be provided is unclear whether these obligations have been fulfilled or as civil rights organisation Section 27 points out it would be unconstitutional to exclude asylum seekers and undocumented people from healthcare services, especially reproductive or including reproductive health services and HIV treatment. Or that limiting the role of medical schemes would violate the progressive realisation of healthcare access. Or denying the right of access to healthcare and freedom of association.

NHI Bill........ continue to page 9

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NHI Bill........ continue from page 8

All of those may be unconstitutional." Kruger was speaking during the opening of a recent webinar hosted by The Institute of Health Risk Managers. "Other concerns that have been expressed include things like the potential flight of skills from the country.

The far-reaching powers of the Minister of Health over the proposed single fund and then concerns around quality and many, many more." Author of The Foundation Principles of South African Medical Law, and The Law of Medical Schemes in South Africa.

Dr Debbie Pearmain addressed the possible constitutional legal challenges the NHI Bill will face during the webinar. "I think a general concern that stretches across the entire proceeding so far is that stakeholders in the private sector feel that they've gone unheard. And I've heard many stakeholders complain that the Parliamentary Portfolio Committee on Health had a very dismissive attitude towards their representations on the Bill.

CONSTITUTIONAL CHALLENGES

"Because the Bill leaves so much to the Minister of Health in terms of decision making about the nuts and bolts of NHI, it's quite likely that we could see constitutional or legal challenges on an ongoing basis to the Bill, as these other regulations and other information emerges because the Bill itself is, at this stage, quite vague," said Dr Pearmain "It's still, I believe, unconstitutional, but it's not as complete as it would be when there are regulations to explain how the government sees the implementation of the Bill going forward." Highlighting the fact that the constitutional requirement of participatory democracy has not been observed, HASA (Hospital Association of South Africa) said that approving the Bill without consideration of recommendations and contributions made by participants is deeply regrettable. "During the Parliamentary Portfolio Committee hearings, when a member of BHF (Board of Healthcare Funders) asked the Committee on Health if they'd read their submission, the committee admitted they hadn't. It's not enough to pay lip service to the process of having hearings and receiving comments, you are supposed to consider them and take them into account. You're not obliged to accept them as government, but if there's been a lack of consideration of comments from key stakeholders then it could be argued that the processing of the Bill is unconstitutional," Dr Pearmain said.

"Some stakeholders object to the Bill's approach to asylum seekers and illegal foreigners. This is one of the things that the parliamentary law advisor also raised in her legal opinion that caused such a stir," said Dr Pearmain. "The rights of asylum seekers and illegal foreigners are restricted by the Bill. Social justice organisations say that key provisions of the Constitution are not reflected in the Bill. Section 27 of the Constitution clearly states that every person has the right to have access to healthcare services, including reproductive healthcare, and no person may be refused emergency treatment. This includes asylum seekers and undocumented persons. The NHI Bill is not consistent with the constitutional rights to equality and human dignity either.

"Furthermore, children's rights in terms of the Constitution, children of asylum seekers or illegal migrants must continue to enjoy the same level of access to healthcare services as currently provided to them.

The term 'basic healthcare services' should be defined and clarified in the Bill. It is not the same as 'healthcare services'."

NHI Bill........ continue to page 10

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NHI Bill........ continue from page 9

Then there are barriers to access of healthcare created by the Bill. “The registration provisions of the Bill may be challenged as unconstitutional barriers to access. Documentation to be provided for registration may prejudice vulnerable persons such as aged persons, the mentally ill etc. Also access to emergency medical treatment is dependent on prior registration with the Fund,” explained Dr Pearmain.

“Referral pathway requirements of the Bill are another barrier to access because they will affect all users and may constitute an unconstitutional denial of care. The Bill is inflexible and makes no provision for users who cannot follow referral pathways.”

WHERE IS THE NHI BILL CURRENTLY?

The Bill must still go through the National Council of Provinces (NCOP). “We don’t know what procedures the NCOP will adopt to facilitate participatory democracy and let everyone have their say again, but they are obliged to allow people to have their say in the provinces as well,” said Dr Pearmain. She advised that those working for stakeholders should lookout for opportunities to make their views on the NHI well known to the provincial legislature in which they operate, or to the NCOP, depending on how they decide to conduct the proceedings.

One of the biggest complaints about the Bill is that it lacks clarity, which is just one of the reasons SAMA has stated that it does not support the NHI Bill in its present form and is waiting for regulations to be published.

One of the biggest complaints about the Bill is that it lacks clarity, which is just one of the reasons SAMA has stated that it does not support the NHI Bill in its present form and is waiting for regulations to be published.

However according to Dr Pearmain: “the regulations are not going to come in the near future because the Bill must be processed through the NCOP and then if all goes well, it goes to the president for assent, that’s the constitutional process. So, regulations could take quite a long time to materialise, and they are likely to be done as and when the sections in the Bill are to be activated.”

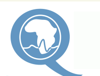
THE ISSUE OF TIMING

While its clear there are several legal challenges likely, Dr Pearmain highlighted the issue of timing. “I’ve already made mention of the fact that the Bill is still being processed and, assuming it all goes well in the NCOP, the President must then assent to the Bill,” she said.

“The state law advisor has said that it’s constitutional, but bear in mind that the state law advisor has said several other pieces of legislation are constitutional and then the courts have found them not to be. And just the fact that we have another legal opinion from the parliamentary law advisor that doesn’t agree with the state law advisor is quite significant. It was clear to me when I read the opinion of the parliamentary law advisor that she had gone back and looked at the submissions, whereas the state law advisor’s legal opinion seemed to just be doubling down on what the state law advisor had already said. The state law advisor didn’t, to my mind at least consider what stakeholders were saying and that’s why there was such a difference between the two legal opinions,” said Dr Pearmain.

“The President can refer the Bill back to the Constitutional Court if he wants the Constitutional Court to determine its constitutionality, but that’s his discretion, he doesn’t have to do that.

NHI Bill........ continue to page 11



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Dr Pearmain explained that the key message was that everyone needed to keep participating in the legal processes: “to make sure that government has no opportunities to say, but you didn’t tell us, because that contributes a lot to the success of litigation. If you had an opportunity to make a submission or do a presentation and you didn’t, then it does weaken your case a little bit.

Not sufficiently, I mean that the constitutionality of the Bill doesn’t depend on whether you made submissions or not, it just goes to show your own integrity as a stakeholder and the fact that you did participate in all the processes throughout which the Bill was taken.”

THE MONEY BILL

Treasury,” said Dr Pearmain. “Only the Minister of Finance can introduce a Money Bill. So, they can’t bring the NHI Act into operation until there is a Money Bill that supports it. So, that’s also something to watch out for, and it must also go through Parliament and be processed by Parliament.

“Until the Money Bill is passed the NHI Act will just lie dormant.”

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A collage of the exhibitors, prize winners and nature walk / 19 August 2023

Johannes Visser, Wessel Mienie & Bronwyn Davidson

George Open Day 2023 ....continue to page 14

George Open Day 2023 ....continue to page 15

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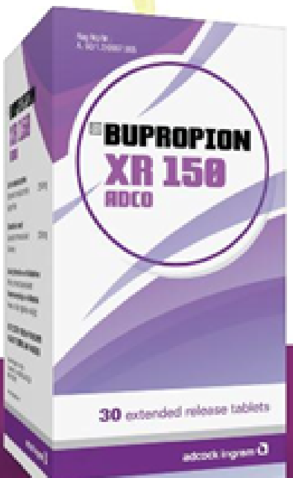

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HPCSA PERSISTS IN ENFORCING REGULATIONS DECLARED ‘UNLAWFUL’

The Health Professions Council of South Africa (HPCSA) continues to punish doctors with hefty fines for contravening regulations which were found to be unlawful by the Competition Commission 12 years ago.

Moreover, reports **News24**, the **South African Medical Association** (SAMA) has accused the national Health Department of not implementing an October 2015 report finding the HPCSA was rife with mismanagement and maladministration.

It said despite being told its rules were illegal and anti-competitive, it has continued to punish health workers, mainly doctors, with fines of up to R60 000 for breaching its unlawful regulations.

The illegality relates to the commission’s 2011 rejection of the council’s application to exempt 10 ethical rules found to contravene the **Competition Act**, according to a November 2011 gazette announcing the commission’s rejection.

SAMA chairperson Dr Mvuyisi Mzukwa said former Health Ministers Aaron Motsoaledi and Zweli Mkhize – and current Health Minister Joe Phaahla – had ignored his association’s repeated pleas to implement the October 2015 report.

Head of the HPCSA’s legal services Advocate Phelelani Khumalo was found by the October 2015 ministerial report to have overseen a “dysfunctional system of professional conduct inquiries which has prejudiced practitioners and the public”.

Law-breaking

Competition Commission spokesperson Siya Makhunga told News24 the HPCSA was still implementing its anti-competitive rules that breach the Competition Act, and that the Commission had tried, since 2011, to “facilitate the amendment of the (regulations) to achieve competitive outcomes”.

Section 59 of the Competition Act states a body can be penalised by the Competition Tribunal should it breach competition laws.

“The engagements were still ongoing when a new process through the Health Market Inquiry (HMI) was launched in 2013 to fully examine the competition issues in the private health sector ... including regulatory issues like the HPCSA ethical rules,” Makhunga said.

“A detailed report of the HMI was published in September 2019, making recommendations on reforms to the HPCSA and the ethical rules, a process that would have to be under the auspices of the National Department of Health.”

Health workers, who will be central to the NHI’s implementation, have faced punitive fines for charges sanctioned by Khumalo on rules found to be unlawful.

News24 sourced a list of 17 doctors charged and found guilty based on the illegal rules, including an optometrist fined a cumulative R60 000 for operating “a mobile clinic for purposes of advertising” in December 2013.

The optometrist operated an eye clinic outside a licensing department office for people applying for driving licences or renewals to do eye tests.

HPCSA persists .... continue to page 18

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Another recommendation was the "unbundling of the HPCSA into at least two entities: the historic Medical and Dental Council (which constitutes a third of the current HPCSA membership) and a Health and Rehabilitation Council (for the rest of the professional membership of the HPCSA)".

"SAMA has on numerous occasions requested the Ministers of Health (Motsoaledi, Mkhize, and Phaahla) to follow through on this – even giving them a draft Bill to assist in the unbundling ..."

On the HPCSA's illegal rules, Mohale said the council had "made progress" in reviewing and amending its rules, with revisions apparently approved in March.

"The only outstanding step... is for these to be gazetted," he said.

However, an HPCSA source the council had not approved anything in March, and only mentioned revisions after News24's questions.

"She was found guilty on three counts, ..."

She was found guilty on three counts, despite the commission stating the rules prohibiting people from operating mobile clinics were unlawful.

Makhunga, meanwhile, said the Competition Commission, in its 2019 market inquiry report, also made findings against the HPCSA to strengthen its role before the NHI's expected implementation.

Health Department spokesperson Foster Mohale said Khumalo had been "exonerated" by the HPCSA because the complaints against him happened before the legal head's arrival.

Mzukwa, representing the medical association, disputed the report was heeded, saying the SAMA had "continuously called for the neglected recommendations of the (October 2015 report) to be implemented".

The **DA** has called for the dissolution of the HPCSA board, and the suspension of its CEO Dr Magome Masike and legal services head Khumalo.

Michele Clarke, DA shadow minister of health slammed the Department of Health and all Health Ministers for failing to implement the recommendations from the 2015 ministerial report.

And in 2019, the Competition Commission's market inquiry report also made findings against the HPCSA ethical rules, especially those regarding fee-sharing, multi-disciplinary group practices, and employment of doctors, she wrote in a statement on the PoliticsWeb site.

"The HPCSA has failed to serve the interests of its members for a very long time. Annually, the DA is inundated with requests for help from unplaced interns and community service doctors, doctors who qualified in foreign countries struggling with accreditation and registration, and concerns that complaints and investigations are being mismanaged.

"This latest revelation shows that nothing has changed since the 2015 report found that under Advocate Khumalo the HPCSA was a 'dysfunctional system of professional conduct enquiries which has prejudiced practitioners and the public'."

Clarke said the "wilful unlawful conduct ... is a terrible omen of the chaos and corruption that will surely trademark the NHI... Given the dire and debilitating circumstances created by the body meant to support them and the NHI threat, no wonder medical professionals are already seeking opportunities elsewhere".

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WHY IT'S IMPORTANT TO UPDATE PERSONAL DETAILS WITH THE HPCSA

It is critical to keep the HPCSA updated on changes to contact details, especially email addresses, writes Dr Yash Naidoo, case manager at Medical Protection, who writes that failure to do so cost one practitioner a R10 000 penalty even though he was found not guilty of the complaint against him.

NAIDOO WRITES:

Last month, we wrote about how we are seeing an improved efficiency in the HPCSA's preliminary handling of complaints against practitioners. We also noted the HPCSA's willingness to consider taking steps to make their investigation processes more efficient and compassionate, as well as recent amendments to their professional conduct inquiry process, which may help curtail the often lengthy ordeal.

Considering the mental, emotional and financial toll the process can have on practitioners and patients alike, these developments are welcome.

While we hope to continue engaging positively with the HPCSA with a view to refining the process, there is one issue we see far too often that stifles the process, and it is squarely within our members' control, and sometimes leads to sanctions against them.

The problem is that in many cases, the HPCSA does not have a practitioner's latest email address in its records.

This is understandable. We may elect to change our email address over time, and for many, the email address used when first registering with the HPCSA all those years ago might have become outdated and replaced with something else down the line. But it is crucial to make sure the HPCSA has your latest email address – the one you use and monitor daily – in its records.

WHY IS THIS SO IMPORTANT?

The answer lies in the early 2020 amendments to the regulations relating to the HPCSA's professional conduct inquiry process.

The effect of the amendments was that a practitioner's email address, as it appears in the records of the HPCSA, may be deemed the address of the practitioner for communications.

After the HPCSA receives a complaint about a practitioner, that person must be notified in writing and a written response to the complaint requested within 40 working days.

According to the regulations, the clock starts ticking on the day the HPCSA emails the notification to the practitioner at the address which is in the HPCSA's records.

Why it's important .... continue to page 20

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Given the regulations, the HPCSA is within its rights to expect a response is due 40 days after having notified a practitioner of the complaint via email at the address saved in its system. Thankfully, in our experience, they are not too rigid in this regard and often take steps to try to contact a practitioner via a phone call or send reminders and warnings about overdue responses.

It is not uncommon for a member to approach Medical Protection for assistance after the HPCSA has provided ample time and in many cases, has re-sent the complaint, to a practitioner's new email address, affording some reasonable leeway.

However, this can lead to self-created urgency on the part of the member, Medical Protection and its experts, in preparing a well thought- out and comprehensive response.
While extensions are generally granted within reason, we have seen cases where the HPCSA has had no choice but to consider a complaint in the absence of a response by a practitioner. Remember, the HPCSA (and the complainant) cannot wait indefinitely.

A consequence of not having your correct details on the HPCSA's system can come in the form of a sanction and penalty.

The regulations allow the HPCSA to summon a practitioner to a meeting to inquire why he or she did not respond to its correspondence. After considering this explanation, the HPCSA must find the practitioner guilty of contempt, and impose a penalty of a caution, a reprimand, a fine, or any combination of these.

This is not an academic issue. I was recently supporting a member in a matter in which the practitioner's explanation to a complaint was accepted by the HPCSA. It found the practitioner did not breach any duty of care and acted reasonably and appropriately in the circumstances. However, the HPCSA nonetheless imposed a penalty of R10 000 for contempt of the HPCSA.

In doing so, the HPCSA reminded the practitioner that the onus was on the practitioner to "check your emails and to respond to Council within the stipulated time".

It is important to remember that, as we have previously discussed, HPCSA fines must be paid by the practitioner personally and may not be paid by their defence organisation or professional indemnity provider.

It is not only in the context of complaints that it is important to keep the HPCSA updated.

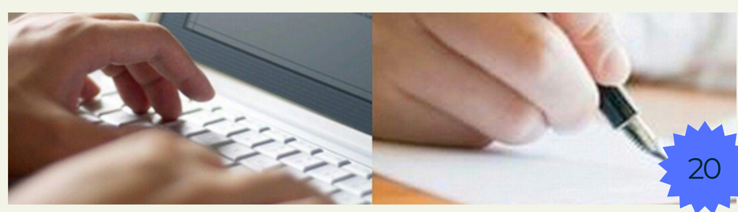
Doing so is part of our obligation as professionals to properly administer our practice. We have previously written about this important obligation. From an administrative point of view, keeping the HPCSA's records updated helps to ensure practitioners pay their yearly registration fees and thus remain lawfully entitled to practise.

Failure to pay your fees on time can result in suspension from the register. Once suspended, a practitioner may not practise until reinstated. Practising while suspended is not allowed, and practitioners will also not enjoy the benefits of membership of a defence organisation or indemnity provider.

Last, the HPCSA occasionally sends important information to practitioners which should be accessed and considered, such as legal bulletins, surveys, notifications about online systems issues, invitations to events, and other relevant matters. These crucial updates will be missed if your details are not captured correctly.

It is essential that every registered practitioner keeps the HPCSA updated. If you are unsure whether the HPCSA holds your correct email address, we strongly recommend you contact them via their website to check.

It may also be prudent to keep your own record of any confirmation of, or changes to your details, by retaining copies of the relevant emails between you and the HPCSA, or screenshots of the website reflecting your correct details.
While we are unable to assist with registration issues, members are entitled to ask for assistance with HPCSA complaints and should get in touch with us as soon as possible after notification by the HPCSA.



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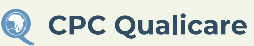

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Health council plagued by **mismanagement**, unfairly punishing doctors

The South African Medical Association (Sama) accuses consecutive health ministers, including the incumbent Joe Phaahla, of ignoring the findings of a 2015 report against the HPCSA.

For 12 years, illegal and anti-competitive behaviour has engulfed the statutory body envisioned to regulate health professionals in the contentious multibillion-rand National Health Insurance (NHI) scheme, the Competition Commission confirmed. The HPCSA, despite being told that its rules were illegal and anti-competitive, has continued to punish health workers, mainly doctors, with fines of up to R60 000 for practitioners who have breached the council's unlawful regulations.
According to SAMA chairperson Dr Mvuyisi Mzukwa, former health ministers Aaron Motsoaledi and Zweli Mkhize and current Health Minister Joe Phaahla ignored his association's repeated pleas to implement the October 2015 report.

The Health Professions Council of South Africa is a statutory body established in terms of the Health Professions Act and is committed to protecting the public and guiding the professions.

Competition Commission spokesperson Siya Makhunga told News24 that the HPCSA was still implementing its anti-competitive rules that breach the Competition Act, saying the commission had tried since 2011 to "facilitate the amendment of the [regulations] to achieve competitive outcomes".

Makhunga said: "The engagements were still ongoing when a new process through the Health Market Inquiry was launched in 2013 to fully examine the competition issues in the private health sector as a whole, including regulatory issues such as the HPCSA ethical rules."

According to the NHI Bill that the National Assembly passed in June, the council will be responsible for registering and accrediting all health workers should the single-fund system be enacted.

Health workers, who will be central to the NHI's implementation, have faced punitive fines for charges sanctioned by Khumalo on rules found to be unlawful.

MEDICAL AID PRICE HIKES FOR 2024 - WHAT TO EXPECT

The Council for Medical Schemes (CMS) in South Africa recommends that medical aids in the country limit their 2024 price hikes to 5% "plus reasonable utilisation estimates".

The council said that historical data points to reasonable utilisation estimates adding around 3.2% to 3.8% to the hikes – thus making the potential increase for 2024 closer to 8.5% – but it has requested that all medical schemes submit data justifying such an increase.

The recommendation was put through to all medical aids in the country through the CMS' latest circular.

As per regulations of the Medical Schemes Act, the Registrar must issue a notice to all medical schemes every 31 July of each year, outlining the requirements involved when submitting contribution increases and benefit adjustments.

To this end, Circular 27 of 2023 was issued and circulated to all 72 (open and restricted) medical schemes.

>>> READ MORE

According to the CMS, over the past decade or so, medical aids have been hiking contributions by far higher than inflation, with medical aids themselves often positing an industry norm of CPI+4%.

This trend was heavily disrupted by the Covid-19 pandemic in 2020, which resulted in below-inflation hikes in 2021 and 2022, with a slight resurgence in 2023 where many schemes opted for deferred price hikes.

"In recent years, costs in the private healthcare sector have been rising faster than inflation, while growth in medical scheme membership has stalled.

"Lack of beneficiary growth, demographic changes and worsening health status of covered lives threaten the long-term sustainability of medical schemes," the CMS said.

Medical aid price hikes for 2024 ....continue to page 23

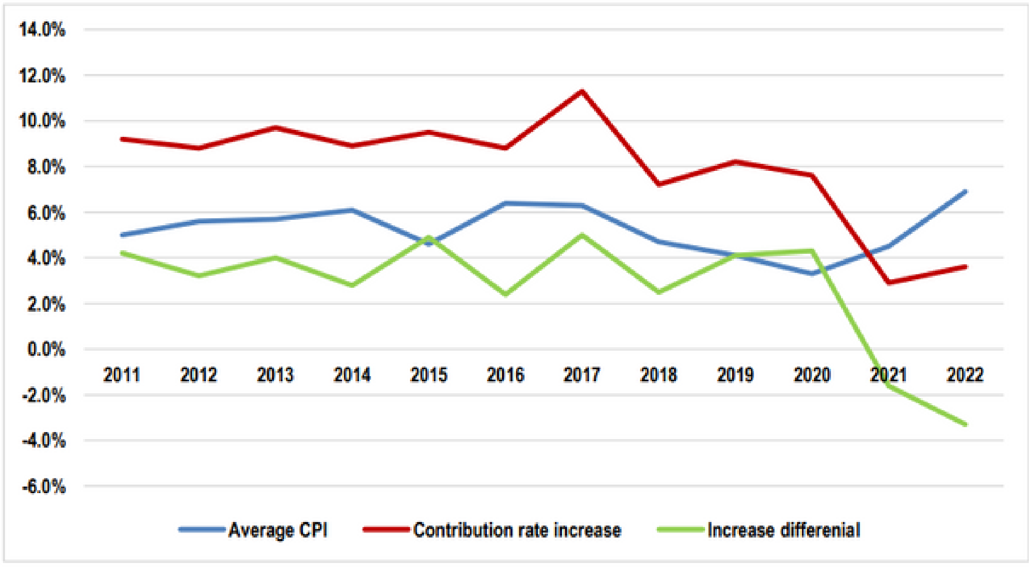

Figure 2: Medical schemes contributions and headline inflation (2011-2022)
Source: CMS Annual Report 2021/2022

In addition to this, South Africa is facing widespread adverse macroeconomic conditions – characterised by multi-year higher interest rates due to stubbornly higher inflation rate, a volatile domestic currency and surging energy prices and overall lacklustre economic growth.

"It is evident that most household budgets will remain constrained for a foreseeable future, leaving most consumers in a precarious financial position," the CMS said.

"To protect medical scheme members from further financial distress and the likely risk of losing health insurance coverage due to affordability constraints, medical schemes are advised to limit their cost assumptions for tariff increases to 5% plus reasonable utilisation estimates for the 2024 benefit year."

>>> REASONABLE UTILISATION ESTIMATES

Medical aids not only have to cover their base costs but also have to plan ahead for the utilisation of the funds.

The CMS noted that the utilisation of healthcare services trajectory was impacted severely in the past two years, with a significant drop in actual utilisation in the aftermath of the Covid-19 pandemic.

While emerging trends points towards a normalisation path and return to the pre-pandemic health-seeking behaviour, there is still a high degree of uncertainty about a clear post-Covid-19 utilisation trends, it said.

Medical schemes must therefore assume reasonable utilisation estimates for 2024 based on historical utilisation data pre-pandemic, the scheme's current demographic profile, as well as more recent available actual claims data," it said.

Cost increase assumptions analysis for 2023 showed that the combination of demographic and utilisation factors are projected to add about 3.2 percentage points to the total cost increases for medical schemes this year.

This projection is lower than the 3.8 percentage points estimate for the 2022 benefit year. Given these estimates, it is assumed that 2024's hike will be in a similar range.

As was the case in the previous year, the CMS said it is concerned that the utilisation estimates submitted by the schemes do not always correlate with the changes in a scheme's demographic and risk profile.

"Medical schemes are thus requested to submit a comprehensive analysis of these factors when motivating for their respective cost increase assumptions.

"Contribution increases higher than CPI plus a reasonably assumed utilisation factor will be evaluated and approved on the strength of the motivation submitted. Only contribution increases that have been approved by the Registrar may be implemented by medical schemes.

"Moreover, it is advised against communicating any benefit changes or contribution increases before obtaining the necessary approval from the regulator," it said.

End

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KEEPING YOUR PRACTICE EFFICIENT: HERE'S WHAT TO DO

When a medical practice isn't functioning well, the problems can quickly compound and lead to poor reviews, lack of communication, and negative attitudes. Patients might notice that follow-up calls don't happen, communication within the practice is haphazard, and the clinical staff seem to be in a perpetual bad mood.

An inefficient practice can lead to a lack of boundaries, mistrust in one another, little to no support for growth, and poor working conditions, which leads to fatigue, burnout, and stress.

"An environment becomes toxic if there's a lack of clear expectations and employees aren't aligned around the vision of the practice," says Adrienne Lloyd, a healthcare consultant based in Chapel Hill, North Carolina. "Add this to such factors as a lack of accountability and this can lead to an extremely stressful work environment and high turnover."

So what's the best way to nip inefficiency issues as quickly as possible given the busy nature of running a practice, including rising patient volume, increased paperwork, and less and less time with each patient?

For starters, everyone has to work together as a team to improve the practice and the relationships between everyone who works there.

Here are six ways to turn an inefficient practice into a healthy one.

Huddle With Your Team Regularly:

Though the frequency of these huddles isn't as important, consistency is. Hold them daily, weekly, or bi-weekly if that makes sense for your practice. "It helps if everyone comes into the office before the first patient is scheduled and checks in on each other," says Lisa McDonald, founder of Integrated Connections, a full-service medical practice growth consultancy specializing in staffing and operations in Fort Collins, Colorado.

"This is the time for everyone to share concerns. The result: Your staff will feel supported, they'll feel like they're working together like a community, and they'll ultimately collaborate more." Longer meetings with the entire staff should take place often too, say, once a month. "Bring in lunch and talk about staffing changes taking place in the practice, new technologies being introduced, and anything else that might be pertinent," she says.

Regular practice meetings can change a practice culture from a one in which everyone is disconnected into one in which every staff member knows what's happening, can voice concerns, feels listened to, and can problem-solve issues together.

Always Express Appreciation For Co-Workers and Staff

If you notice that a co-worker seems unhappy, distracted, or short, start the conversation from a perspective of caring about that person, not criticizing them. "The first question I'm going to have when I pull a colleague aside for a tough conversation is 'Hey, how are you doing/how's work going?'" says Jimmy Turner, MD, an academic anesthesiologist at Wake Forest University School of Medicine and co-founder of Attend, a financial wellness company for physicians.

Keeping Your Practice Efficient .... continue to page 26

Get to the Root Cause of Issues

When you learn there's tension between employees (or between partners at the practice), first, gather information by doing a brief interview with one or both of the individuals involved. And instead of criticizing, pose a question about the situation. "Instead of saying 'Why is this happening,' ask the person for his or her ideas of how to shift this from a problematic interaction to a positive one." Lloyd says.

"The reality is that this might be a misunderstanding, or the person needs more training — it's always best to be open to the fact that the person didn't do something intentionally."
Getting staff members who've had a negative interaction with one another to move on is the goal. Sometimes that means pairing them on projects; other times that may mean giving them some space. Your goal is fostering a more positive interaction between them so they can work together professionally.

Institute a 'Zero Reset' Day

Once issues have been resolved, keep those problems in the past, Lloyd says. "In addition, this is the perfect time to set new rules of behavior," she says. "For example, 'From this point forward, we're not tolerating showing up late and we're not accepting negative comments; instead, here's the atmosphere we'd like to create in our office.'"

Then, you can brainstorm how to get team members working together and taking ownership of small pieces of the practice.

Check Your Reviews

When an employee leaves your practice, they may post a review on Yelp, Google, or Glassdoor. Checking these write-ups is critical, McDonald says. "Any employee who has left can say damaging things about you," she says. "It's critical that you're aware of your online presence and if you sense a pattern in what your ex-employees are saying, you need to pay attention."

Optimally, when an employee leaves, you should have an exit interview where they can share their experience working for the practice, discuss any weaknesses or problems they noticed, and be free to share how they wished things were handled.

These interviews are invaluable for seeing the practice through the eyes of an employee and taking their words to heart to make any necessary changes.

Always Be Direct

To keep your practice healthy, it's just as important to know when it's time to let a person go because their behavior and competence can negatively affect your practice. In addition, keeping an employee who is not up to par usually affects the rest of the team negatively because they can become resentful and frustrated.

This is especially true if you've had multiple discussions with an employee, and they haven't improved the problem. They should already know what the issues are and had an improvement plan to work on.

"When you fire someone, remind that person that you've discussed the applicable issues multiple times," Turner says. "Sometimes people aren't the best fit for your office and your employee may actually be relieved to be let go." Use direct language being honest and compassionate.
Turning an inefficient practice around can be challenging, but when you communicate with your team compassionately and regularly, get to the root of problems, and express appreciation and concern, inefficiency doesn't stand a chance.

End

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EFFICACY OF A CLINICAL DECISION RULE TO ENABLE DIRECT ORAL CHALLENGE IN PATIENTS WITH LOW-RISK PENICILLIN ALLERGY

The PALACE Randomized Clinical Trial

Key Points

***Question** Is direct oral penicillin challenge in adults with a low-risk penicillin allergy, defined as a PEN-FAST score less than 3, safe and effective compared with the standard-of-care penicillin skin testing followed by an oral penicillin challenge?*

Findings In this randomized clinical trial of 382 patients across 6 centers in 3 countries, a positive penicillin oral challenge consistent with an immune-mediated reaction occurred in 0.5% of both the direct oral challenge intervention group and the control group, with an upper 1-sided confidence interval below the noninferiority margin of 5 percentage points.

Meaning In adult patients with a low-risk penicillin allergy, direct oral penicillin challenge is a safe and effective procedure that may facilitate the removal of a larger number of penicillin allergy labels.

Abstract

Importance Fewer than 5% of patients labeled with a penicillin allergy are truly allergic. The standard of care to remove the penicillin allergy label in adults is specialized testing involving prick and intradermal skin testing followed by an oral challenge with penicillin. Skin testing is resource intensive, limits practice to specialist-trained physicians, and restricts the global population who could undergo penicillin allergy delabeling.

Efficacy of a Clinical Decision ....continue to page 28

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Objective: To determine whether a direct oral penicillin challenge is noninferior to the standard of care of penicillin skin testing followed by an oral challenge in patients with a low-risk penicillin allergy.

Design, Setting, and Participants

This parallel, 2-arm, noninferiority, open-label, multicenter, international randomized clinical trial occurred in 6 specialized centers, 3 in North America (US and Canada) and 3 in Australia, from June 18, 2021, to December 2, 2022. Eligible adults had a PEN-FAST score lower than 3. PEN-FAST is a prospectively derived and internationally validated clinical decision rule that enables point-of-care risk assessment for adults reporting penicillin allergies.

Interventions

Patients were randomly assigned to either direct oral challenge with penicillin (intervention arm) or a standard-of-care arm of penicillin skin testing followed by oral challenge with penicillin (control arm).

Main Outcome and Measure

The primary outcome was a physician-verified positive immune-mediated oral penicillin challenge within 1 hour postintervention in the intention-to-treat population. Noninferiority was achieved if a 1-sided 95% CI of the risk difference (RD) did not exceed 5 percentage points (pp).

Results

A total of 382 adults were randomized, with 377 patients (median [IQR] age, 51 [35-65] years; 247 [65.5%] female) included in the analysis: 187 in the intervention group and 190 in the control group. Most patients had a PEN-FAST score of 0 or 1. The primary outcome occurred in 1 patient (0.5%) in the intervention group and 1 patient (0.5%) in the control group, with an RD of 0.0084 pp (90% CI, −1.22 to 1.24 pp). The 1-sided 95% CI was below the noninferiority margin of 5 pp. In the 5 days following the oral penicillin challenge, 9 immune-mediated adverse events were recorded in the intervention group and 10 in the control group (RD, −0.45 pp; 95% CI, −4.87 to 3.96 pp). No serious adverse events occurred.

Conclusions and Relevance

In this randomized clinical trial, direct oral penicillin challenge in patients with a low-risk penicillin allergy was noninferior compared with standard-of-care skin testing followed by oral challenge. In patients with a low-risk history, direct oral penicillin challenge is a safe procedure to facilitate the removal of a penicillin allergy label.

Trial Registration ClinicalTrials.gov Identifier: **NCT04454229**

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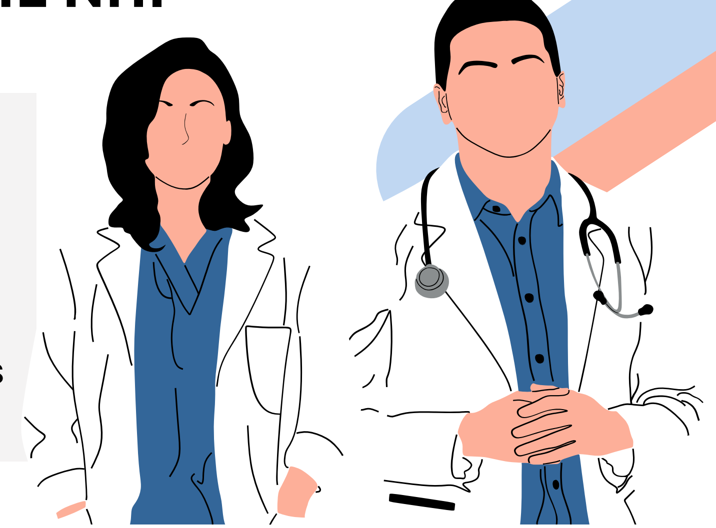
WHAT GOES INTO YOUR MEDICAL AID PREMIUM – AND WHAT IT MEANS FOR THE NHI



Earlier this month, the Council of Medical Schemes (CMS) – the body that regulates private medical aids in South Africa – announced that 2024 monthly premiums should best not increase by more than 5%. But if schemes get permission, they might go up by 8%.

Each year, the CMS determines what type of increase is reasonable. But how do medical schemes calculate premiums and is this different from the way in which the proposed National Health Insurance (NHI) scheme will do it once the much debated NHI Bill has been passed?

There are similarities, but also big differences.
The NHI will buy healthcare services for its members — all South Africans and also those non-South Africans who live here and qualify — with a central pool of funds, just like private medical schemes do.

Privately run medical schemes such as Discovery Health or the Government Employees Medical Scheme are not-for-profit trusts made up of funds from their members' monthly contributions. This means the money belongs to the members, for their benefit, not the scheme's administrators.

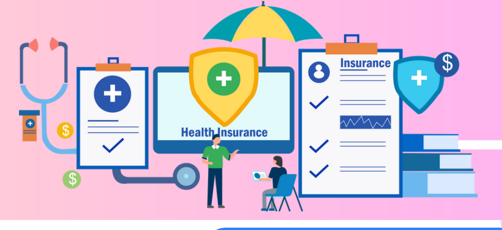
When someone who contributes to the fund needs a health service, the scheme pays providers such as doctors and hospitals directly from the pool of funds once they've delivered the service.

The fee depends on the type of service that was offered and is set out in a medical aid's schedule every year.

But while your medical aid uses a fee-for-service model, which means it pays for each service individually once rendered, the NHI will use a capitation model. This means it will calculate how much to pay a service provider based on how sick or healthy people in a certain area are, using a formula that calculates how many patients that provider is likely to see in a particular year.

According to the current plan for the NHI's payment model, it will give a set amount of funds to administration units in each of South Africa's 52 health districts.

These units will then contract providers for different services, whether it's eye care, vaccinations, health screens, general GP visits or anything else that will be included in a fixed, basic package of services, and pay them a set fee in advance based on the number of patients expected to need a specific service in the area.



What goes into your medical aid premium .... continue to page 30

But just as your medical aid does now, the NHI will negotiate with service providers to decide on a fee structure that makes sense, so that they're "involved both in designing and [setting] the scope of the contract", says Victoria Barr, a health economist and consultant to the health department for the NHI.

Here are four things' economists and actuaries — and for whose appointments in the NHI the health department has given the go-ahead last year — look at when deciding on how much members should contribute to a medical scheme's pool of funds.

1. How much should a package of health services cost?

Every year, number crunchers at medical schemes estimate how many claims they expect to get for a specific service — say, chemotherapy treatment for cancer or surgery for joint

replacement — from their member pool. This gives them an idea of how much money they'll need to have available to cover these services for all their members.

They therefore track usage patterns to see whether the demand for a service might go up or down, or stays steady over time. For example, if the number of claims for specialist services, such as seeing a cardiologist, seems to remain steady over time but claims for GP visits increase, then the scheme needs to plan for these when calculating how much money they'll need in the fund to cover these payments.

But since a court ruling in 2010 said the rates set out in the now-defunct National Health Price Reference List (a list of set rates that capped how much a service provider was allowed to charge a patient) were "unreasonably low", the costs of healthcare services in South Africa aren't regulated. This means providers and hospitals can choose to charge whatever they like for the service they provide.

To keep costs manageable, schemes therefore set their own tariffs for services, with an upper limit for how much they will pay for a service depending on how the benefit package is made up. If someone chooses to see a health professional who charges more than the set price, they have to pay the difference between the medical aid's contribution and the actual fee out of pocket.

2. Should the cost for health services increase?

The administrators of a medical scheme also have to factor in whether the cost of things like equipment, consumables (such as protective masks, gloves and swabs) and running a practice will increase next year because of inflation, for example — and by how much.

Every year in July, the CMS recommends what a reasonable increase in a scheme's premiums would be for the next year. For 2024, they've said tariff increase assumptions should be limited to 5% plus what is reasonable for services' use, which they "cautiously anticipate" to be about 3%, says Mondi Govuzela, senior manager of benefits at the CMS. This means premiums should ideally not go up by more than 8% next year.

Schemes can ask for a higher increase to be approved if they can show the CMS that this would be justified. These requests have to be submitted by October each year, with the council then announcing their decisions in November for new prices to come into effect, usually from January every year.

3. How many people will get sick each year?

Private healthcare services can be expensive. On average it costs about R600 000 for a year's renal dialysis in the private health sector for treating a single patient with kidney disease, said Deon Kotze, chief product officer at Discovery Health, at a media workshop in July. If a member pays, say, R1 900 to their medical scheme every month, it would take about 27 years' of their contributions to cover the cost.

What goes into your medical aid premium .... continue to page 32

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What goes into your medical aid premium .... continue form page 30

Medical schemes make it easier to afford treatment by relying on cross-subsidisation. Simply put, this means the contributions from people who are young and healthy, who generally don't get sick often and so aren't expected to have big medical expenses, can go towards helping to cover treatment costs for older people or those with a higher chance of falling ill. In turn, this group of young, healthy people benefit in the same way when they get older, when a new group of younger members will subsidise their expenses.

But every member of a medical aid qualifies for a set package of basic services, which schemes have to pay in full — these services are called prescribed minimum benefits.

They cover treatment for any medical emergency, 26 chronic diseases and 271 other conditions, including diabetes and different types of cancer. This means every member of the scheme can get treatment for these, regardless of the package they're on or if their benefits for the year have run out.

Administrators of medical schemes estimate that, over the course of a year, only a small proportion of their member pool need more money to pay their doctors' bills than the amount they pay a month.

An analysis by Discovery Health showed that roughly eight out of 10 healthy members of medical schemes contribute more money into the pool than what they claim. In this way people with higher health costs can get life-saving treatment at an affordable price when they need it, while paying the same monthly premium as everyone else, says Kotze.

The NHI hopes to do the same thing: make treatment available to people who would otherwise not be able to afford it.

In South Africa, as much money is spent on the public health sector as on the private sector. But the state system has to service about three-quarters of the population, which means that there's an unequal supply of resources and providers.

While the NHI's funding model has not been finalised, this national insurance will probably be funded by tax allocations and contributions (in the form of payroll taxes) from every citizen, based on their income bracket. In this way, people who can't afford to contribute will still be able to see a doctor through other people's contributions.

What goes into your medical aid premium .... continue to page 33

 .... continue form page 32

4. What do trends in illnesses and treatment look like?

Health economists and actuaries have a good idea of the trends for illnesses and treatments in a year. For example, every year more than 10 million South Africans are expected to get flu, so a medical scheme can plan fairly well how much money they'd need to have available for medicines, GP visits or vaccinations.

But trends also change over time. For instance, as a population gets older, their need for healthcare increases and so the cost for services would go up. South Africa's population is getting older.

Between 2012 and 2022, the number of people older than 60 increased by 1.5 million people, making up close to 10% of the total population. Having an older population means the chance of chronic conditions such as hypertension, diabetes and cancer increases.

Medical schemes look at these patterns to plan how much money will be needed in the pool to cover all their members for the following year.

"We have to look at what the cost per claim is likely to increase by, as well as whether the number of claims per person is likely to change because we've got a population that's getting older and sicker," said Roseanne Harris, health policy actuary at Discovery Health.

Trends can also change suddenly. In such cases premiums might go up — or even drop. If, say, more people get sick in a year because of a disease outbreak or environmental change, costs can go up. On the other hand, if more people choose to see a nurse instead of a GP for a minor illness or a routine service like a vaccination, costs could go down.

Take the Covid-19 pandemic and lockdown in 2021, for instance. During this time fewer people used services such as emergency rooms, out-of-hospital GP visits and non-essential surgeries.

Instead they chose to speak to their doctors virtually or on the telephone, which was cheaper and so allowed medical schemes to build up a reserve of funds in the pool that weren't being spent and so reduce the increase of premiums for 2022.

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Is AI The Answer To Africa's Healthcare Sector Woes?

The African healthcare industry faces an immediate challenge: a dire shortage of skilled professionals, leading to alarmingly low doctor and nurse-to-population ratios in many countries.

Training medical professionals, especially specialists like pathologists or oncologists, is a multi-year-long process. Moreover, foundational education at the primary and secondary levels is crucial to supply tertiary institutions with a stream of candidates equipped with the necessary aptitude, literacy, and numeracy skills to pursue medicine.

Recent technological leaps catalyzed by the COVID-19 pandemic and expanding telecommunications infrastructure, including ventures like Starlink, have bridged some of the distance between communities in need of medical services.

Telemedicine offers those with limited physical access to healthcare professionals a chance to benefit from their expertise. Still, the scope of what can be accomplished via a video call is limited. Accurate diagnoses are particularly challenging.

Medical professionals rely heavily on information relayed by patients or, in the best-case scenarios, by lesser-skilled colleagues following instructions remotely.

Compounding these issues, Africa grapples with a healthcare brain drain. To shore up shortages in their healthcare systems, "developed" markets actively poach African healthcare workers, further depleting the continent's medical resources.

It's within this landscape that artificial intelligence (AI) emerges as a revolutionary force in healthcare. Its precise deployment can mean the difference between life and death in underserved areas and can dramatically reduce healthcare costs in the neediest markets.

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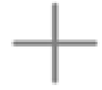

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Upcoming Event

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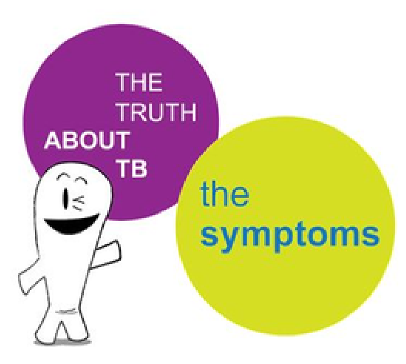

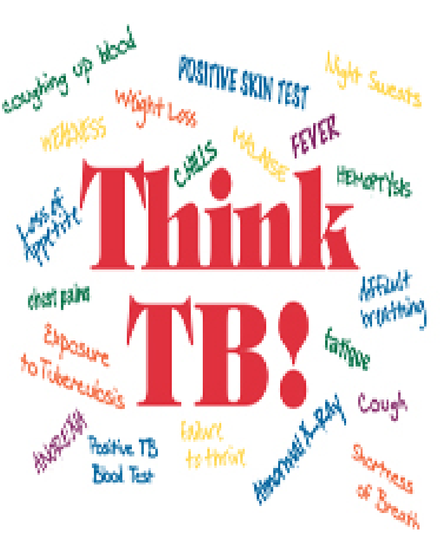

South Africa TB vaccine demonstrates 100% protection

The Walter Sisulu University and North-West University in South Africa unveiled the results of their preclinical trials for a combination vaccine against tuberculosis (TB) and Covid-19.

The universities reported an unprecedented 100% protection in vaccinated animals – a significant step forwards in the unrelenting battle against tuberculosis, one of the world's most devastating diseases. "Tuberculosis is not just a local problem. It is the leading cause of death in South Africa and many other countries," explained Prof. Anne Grobler, a global biotech and pharmaceutical expert and project manager of the South African vaccine platform for infectious diseases (SAVAC) initiative for both universities, who successfully commercialised another home-grown technology in bio-agriculture on an international scale. "To imagine we might be on the brink of defeating this insidious disease is truly electrifying."

The Walter Sisulu University Medical School, whose research is informed by essential national health priorities, collaborated with the North-West University, a trailblazer in drug development and research, on this project. Initiated 18 months ago, their collaborative research was also bolstered by a CHIETA (the Chemical Industries Education & Training Authority) grant.

At the forefront of this multi-purpose vaccine development is the esteemed ProfMarkus Depfenhart, the inventor and driving force behind the concept and development of the vaccine. Last year Prof Depfenhart, who holds extraordinary appointments as professor at both the universities, was honoured with a Walter Sisulu University honorary doctorate for his pioneering work in vaccine and gene therapy in Africa.

Reflecting on the revolutionary nature of this vaccine, Prof Depfenhart shared: "DNA vaccines have incredible potential due to their stability and adaptability. By marrying their strengths with the high efficacy of mRNA vaccines, we are breaking new ground. This union brings out the best of both worlds and could herald a pivotal shift, especially for regions like Africa."

The results from three different immunogenicity studies in two animal models led to, and justified the performance of an effectivity study in an animal model that mimics tuberculosis in humans.

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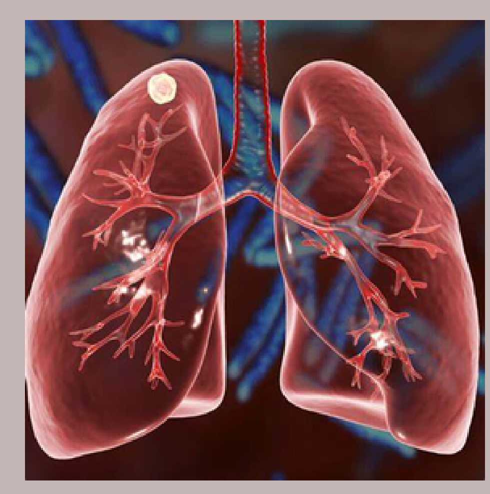
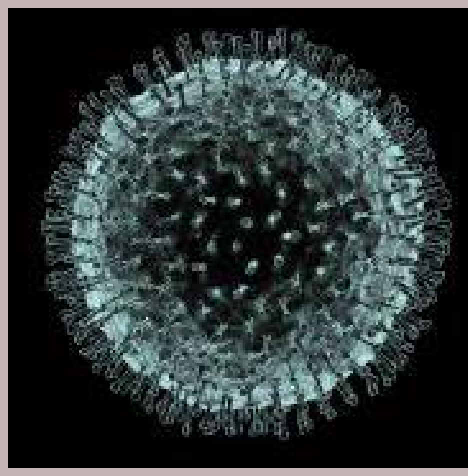
The key deliverable of the study, which was carried out at the high-security biosafety laboratory (BSL3) of the preclinical imaging facility of the South African Nuclear Medicine Research Infrastructure (SANuMeRI) housed at NECSA (South African Nuclear Energy Corporation), was survival. Indeed, the study showcased a 100% protection rate for the vaccinated animal subjects, a feat not previously described in literature. Prof Depfenhart commended the NECSA team, declaring: “The dedication and sacrifices made by the NECSA team during this intense study period were invaluable.”



A standout feature of this vaccine is its unique ability to mirror bacterial protein production, potentially bypassing certain human protein modifications. This ensures that the immune system is introduced to the most authentic version of the antigen, essentially acquainting it with the “true enemy”. When confronted with a real infection, the immune system can then respond more swiftly and effectively. This novel approach, developed by Prof Depfenhart, could be groundbreaking and may well explain the vaccine’s notable efficacy against TB.

With such remarkable results, the next step is to move swiftly into human trials. Preparations for discussions with the South African Health Products Regulatory Authority (SAHPRA) are underway to determine the requisite standards and protocols.



Prof Rushiella Songca, the vice-chancellor and principal of the Walter Sisulu University, encapsulated the prevailing optimism: “We are not merely talking about another vaccine; this is a beacon of hope. Given TB’s unyielding onslaught over the years, standing on the precipice of a tangible solution is epoch-making. Through this venture, our scientific community is signalling that no challenge is insurmountable.”

Elaborating on the collaborative spirit of the initiative, Prof Awie Kotze, executive dean of Health Sciences at the North-West University, extended his profound gratitude to Prof Depfenhart, Prof Grobler and the entire collaborative team. “Prof Depfenhart’s creative impact and innovative drive have been the backbone of this project. His generosity in donating an exclusive worldwide licence for this vaccine, specifically tailored for the African populace, reaffirms his reputation as a leading figure in medical innovation. His influence on this endeavour and beyond is immeasurable.”

Prof Jeffrey Mphahlele, deputy vice-chancellor for Research and Innovation at the North-West University, could not contain his pride and excitement. “The diligence, fervour and ingenuity of this team have been nothing short of astonishing. Having managed to keep such a fast-moving initiative under the radar and then to unveil results of this magnitude is a testament to our team’s prowess.”

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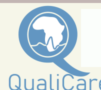

'Patients Fail' Despite Benefits of Sustained Weight Loss

Don't look for the publication of a study detailing the probability of blood pressure reduction to normotensive among adults with **hypertension** who aren't offered pharmacotherapy in a JAMA journal. It's not because hypertension doesn't respond to intentional behavior change. On the contrary, it absolutely does, but when it comes to hypertension, physicians don't require patients to fail to manage their hypertension through personal responsibility before medications are discussed and involved.

Not so, of course, with **obesity.**

A few weeks ago a paper was published in JAMA Network Open entitled **"Probability of 5% or Greater Weight Loss or BMI Reduction to Healthy Weight Among Adults With Overweight or Obesity,"** which authors, peer reviewers, and editors deemed worthy of publication. Now, to be fair, it might be worthy of publication if the call to action and thrust of the paper was to chastise physicians for not offering patients effective treatments; the medical education system for failing to teach physicians how to effectively manage obesity; or, if medication is being offered, addressing the barriers to its use. Instead, the main thrust was that patients are failing to help themselves despite the known health benefits of sustained weight loss.

It's not at all surprising that despite known benefits, sustained weight loss without pharmacotherapy or surgery is elusive. Just as with virtually every other chronic noncommunicable disease with lifestyle levers, intentional behavior change as treatment — which, by definition for chronic diseases, needs to be employed in perpetuity — requires wide-ranging degrees of privilege and is not a reasonable expectation. And if outcomes from the FREEE trial are applicable broadly, this may be true even if the behavior change required is minimal, the cost is free, and the motivation is large.

The FREEE trial studied whether cost had a role to play in why so many people, even after a myocardial infarction (MI), don't follow through with the simplest of intentional behavior changes — taking prescribed medications — by providing free medications known to reduce the risk of having a second MI to study participants who had just suffered an MI.

Results showed that although the group receiving free medications were taking more of them than the group that had a copay for them, at 1.5 years post-MI, only 41% of those receiving all their medications for free were taking them.

'Patients Fail' .... continue from page 40

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And what of those who have a copay? This study found that fewer than 30% of Medicare beneficiaries 65-74 years of age who were hospitalized for heart attacks filled their new statin prescriptions within 90 days of discharge. That the vast majority of patients who'd had actual heart attacks didn't even take on the behavior change of simply filling their prescription for, let alone taking, a medication shown to reduce their risk of having another heart attack, speaks to the folly of believing that knowledge drives behavior change.

The message is that human beings, even when faced with knowledge — and in the aforementioned studies, knowledge coupled with a very real glimpse of personal mortality — struggle to deploy the most basic of behavior changes. And yet here we have a paper that concludes with the inference of surprise that few people, without treatment, lost clinically meaningful amounts of weight "despite the known benefits of clinically meaningful weight loss."

While this paper does suggest in passing that yes, maybe we should offer effective treatments to patients with obesity, medicine needs to stop framing obesity as some surprising personal-responsibility knowledge gap and instead focus on the real problems at hand: the barriers to physicians treating obesity as they do every other chronic noncommunicable disease; why, unlike hypertension, for example, primary care providers are generally not well trained in its effective management; and why those who aren't, despite obesity's prevalence and impact, don't see it as worthwhile to go out of their way to learn.

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Brain's 'appetite control center' different in people who are overweight or living with obesity

- **Researchers report that regions of the brain are larger in young adults with obesity and other weight issues.**
- **They say inflammation in the brain may influence appetite and hunger.**
- **Experts say you can reduce inflammation in the body by eating a healthy diet with fewer fats and processed foods.**

The hypothalamus, a small region in the brain, was significantly larger in young adults who had obesity or were overweight in a new study published in the journal Neuroimage: Clinical.

Researchers also reported there was a significant relationship between the volume of the hypothalamus and body mass index (BMI) among study participants.

The hypothalamus works as a control centerTrusted Source for hunger and feeling full. However, there is a minimal amount of information about this brain region, partially because it is small and difficult to see in MRI scans.

The researchers pointed out that previous research on animals shows that there are interacting pathways between the hypothalamus and other cell populations acting together in the brain's "appetite control center" to tell us when we are hungry and when we are full.

How inflammation can affect the brain

The researchers suggest that inflammation may play a role in these brain relationships.
For example, they explain that previous animal studies show that high-fat diets cause inflammation of the hypothalamus and can lead to insulin resistance and obesity.

Some studiesTrusted Source suggest that chronic inflammation of the hypothalamus can cause a necessity to eat more before feeling full.

The researchers employed an algorithm that used machine learning to analyze scans of 1,351 young adults with a range of BMI scores. They found that the hypothalamus was significantly larger in those with obesity or overweight.

The researchers did not determine whether the inflammation is a cause or consequence.

"We knew the hypothalamus was involved with hunger," said Dr. Mir Ali, a bariatric surgeon and medical director of MemorialCare Surgical Weight Loss Center at Orange Coast Medical Center in California. "But we have so much more to learn."

Brain's 'appetite control center .... continue to page 43

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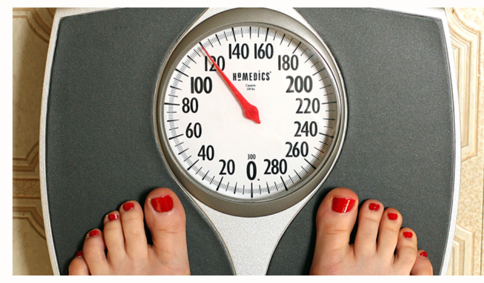

"One concern is inflammation. The researchers suggest this could play a role, but if there is inflammation in any part of the brain, it is very serious," Ali told Medical News Today. "We must look at all factors that might contribute to a person's obesity. The hypothalamus might be one. Physicians can check their patient's hormone level, but problems with this are rare."

"We should treat obesity as a long-term illness," he added. "There are new medications available that are very effective. But these should be used as a tool to help people make long-term changes, not as the only treatment."

Obesity in the United States

The World Health OrganizationTrusted Source defines overweight and obesity as abnormal or excessive fat accumulation that presents health risks.

A BMI of more than 25 is considered overweight and over 30 is considered obese. According to the Centers for Disease Control and PreventionTrusted Source (CDC), the last reported incident rate in the United States (2017) was nearly 42%. It had increased from 30% in 1999.

Obesity and overweight increase the risk of developing heart disease, stroke, type 2 diabetes, and some types of cancer.

These conditions are among the leading causes of preventable, premature death. They are also associated with poorer mental health outcomes and reduced quality of life.

How to manage fats in the diet

Experts say getting to a healthy weight is not easy. Often, people need help.

Ali suggests starting with your primary care doctor for a full evaluation and having any health issues addressed before starting a diet and exercise program

"Look closely at your diet and start with small changes and build upon those. The same goes for exercise," he said. "For people with a BMI between 30 and 40, diet and exercise interventions, including medications might work. However, for people with a BMI of over 40, weight loss surgery might be necessary."

Anne Danahy, a registered dietician and the owner of the website Craving Something Healthy, offers the following tips to Medical News Today for reducing your weight:

- Remember, not all fat is bad for you. Eating healthy fats such as nuts, seeds, nut butter, and avocados can help balance your meals and promote satiety. Adding some healthy fats with meals and snacks can help fill you faster and keep you feeling full for longer, so you eat less throughout the day.
- Most highly processed foods (packaged snack foods, fast foods, frozen dinners) contain unhealthy fats. These promote inflammation and contribute to weight gain, especially belly fat, which harms your health. If you rely on these foods for convenience, avoid them for a few weeks. Cook more meals at home and snack on fruits, vegetables, and nuts. Most people who go on a "fast food fast" are amazed and how quickly they lose weight and how much better they feel when eating whole foods.
- Avoid saturated fats such as butter, cream, large amounts of cheese, and red meats. Replace these with olive oil, lower-fat milk, skinless poultry, and fish when possible.
- Often, excess weight is due to too much sugar or refined carbs in your diet. Be conscious of how often you eat desserts, starchy snacks such as crackers or chips, and sugar-sweetened beverages. Cutting back on these can promote weight loss.

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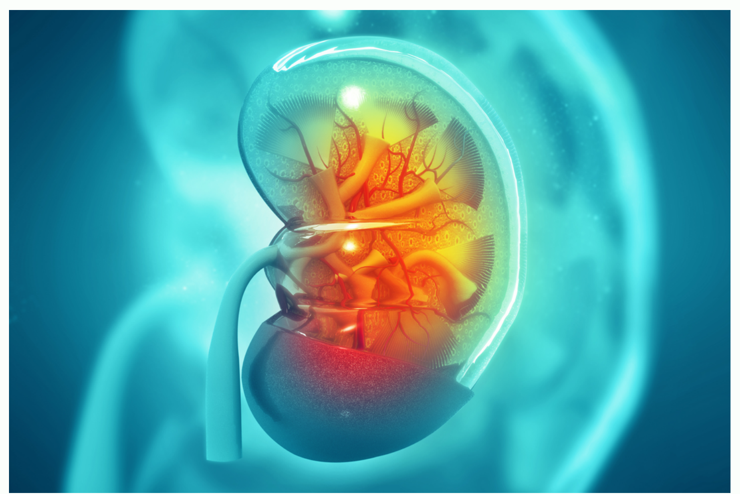
CONSUMING ADDED SUGAR COULD INCREASE YOUR RISK OF KIDNEY STONES



- New research shows that added sugar consumption may be a risk factor for developing kidney stones.
- The negative health effects of added sugar, such as high blood pressure, insulin resistance, and obesity, are also risk factors for kidney stone formation.
- Added sugars can also lead to less urine volume and elevated urinary calcium, which may lead to the development of kidney stones.

Kidney stone formation is a painful condition that may cause vomiting, bloody urine, fever, and chills and interfere with quality of life.

Risk factors for kidney stones include obesity, diabetes, and inflammatory bowel disease (IBD).

New research suggests added sugar intake may be a risk factor for developing kidney stones.

The study authors analyzed data from 28,303 adults between 2007 and 2018 from the National Health and Nutrition Examination Survey (NHANES)Trusted Source.

The data included the participants' history of kidney stones and their daily intake of added sugars, determined by their self-reported recent consumption of food and drinks.

Study shows added sugar leads to kidney stone formation

The study authors defined added sugar as "sugars or caloric sweeteners added to foods or beverages during processing or preparation to add flavor or extend shelf life."

Participants included in the survey were given a healthy eating index score (HEI-2015), which outlined their eating habits.

Researchers also examined factors such as gender, age, race or ethnicity, BMI, and medical history to see if any of these factors may play a role in developing kidney stones.

Researchers discovered that participants who consumed more added sugar were more likely to have kidney stones, a lower HEI score, and a lower education level.

Furthermore, the percentage of caloric energy intake from added sugars was linked to kidney stones.

Participants who received more than 25% of their total energy from added sugars had a 88% higher chance of developing kidney stones than those with less than 5% of their total energy from added sugars.

Why does added sugar intake cause kidney stones?

Medical News Today spoke with Dr. David S. Goldfarb, clinical chief of nephrology and co-director of the Kidney Stone Prevention Program at NYU Langone Health, who was not involved in the study:

Brain's 'appetite control center .... continue to page 46

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"There has long been evidence that sugar increases the amount of calcium in urine, and there have been multiple reasons why avoidance of sugar would be part of a diet encouraging kidney stone prevention. This study serves as a large dataset with good credibility and includes a relatively representative group of people in the United States."

Added sugar can lead to various health problems, such as high blood pressure, insulin resistance, and obesity, all of which increase the prevalence of kidney stone formation.

"From this point of view, the study is important because it documents what we have been telling patients – to avoid this kind of added sugar," said Goldfarb.

"Added sugars can also cause increased weight gain, which is associated with high blood pressure, insulin resistance, metabolic syndrome, and diabetes — all of which are considered risk factors for increased rates of kidney stones. In general, dietary changes that support kidney health are also associated with decreased rates of kidney stones."

In relation to urinary issues, added sugars are responsible for less urine volume and elevated urinary calcium. These both contribute to the development of kidney stones.

MNT also spoke with Dr. Gregory Buller, nephrologist and associate chief medical officer at Bridgeport Hospital, part of Yale New Haven Health, who was not involved in the study:

"It has been known since the late [1960s] that added sugars increased urinary calcium excretion and decreased urine volume (a very bad combination with respect to stone formation) in individuals who had developed kidney stones or their families. This relationship between elevations in urinary calcium (hypercalciuria) coupled with decreased urine volume — major determinants of kidney stone formation — and added sugars likely explains the reason for the increased stone formation. This relationship between added sugars and hypercalciuria adds considerable credence to the study's findings."

Health risks of added sugar consumption

Added sugars can be found in sugary drinks, cookies, cakes, and candy. Many foods contain hidden added sugars as well.

Besides the increased risk of kidney stones, there are many reasons to avoid consuming added sugars.

"Fructose in added sugarsTrusted Source (which are often sucrose — a combination of glucose and fructose) has been shown to increase visceral fat, serum triglycerides, and insulin resistance in overweight individuals, even with short-term intake," Buller noted.

"These are factors long associated with vascular disease, high blood pressure, and heart disease."

Buller added that a healthy lifestyle should include limiting added sugars as much as possible, especially if a person has overweight or obesity, or has a history (or a family history) of kidney stones.

Limitations of self-reporting in studies

When the data is based on self-reported information (as is the case in this study) it can affect the accuracy of the results. Further research is needed.

"It should be noted that studies such as the one just published—a so-called 'observational study'–are limited by the accuracy of individuals' recollections and the fact that confounding factors other than added sugars may have explained the described association," said Dr. Buller.

"Such studies are often termed 'hypothesis-generating studies' since more rigorous types of studies are necessary to actually prove the postulated causative association. Nevertheless, this study, when added to previous work, strongly suggests that added sugars indeed increase the risk for kidney stones."
— Dr. Gregory Buller, nephrologist

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Medicines Information Centre

Answer to an interesting Question

QUESTION:
A patient is on rivaroxaban for atrial fibrillation and now requires surgery for a knee replacement. How long before surgery should the rivaroxaban be stopped and is bridging therapy with low molecular weight heparin needed?

ANSWER:
The patient needs to be assessed in terms of risk of thrombosis vs risk of bleeding due to the surgical procedure. There are various tools available to assist with this. For this patient, thromboembolic risk will depend on age and co-morbidities.

Knee replacement is regarded as a high-risk bleeding procedure. Direct oral anticoagulants (DOACs) can be paused for a shorter period of time as their effect ceases rapidly on discontinuation and likewise resumes quickly on restarting. For this reason, bridging therapy is seldom necessary.

Generally, they can be stopped 24 hours before surgery for low-risk procedures and 48 hours for high-risk procedures, with the same time window post-surgery before restarting.

NOTE:
Treatment decisions like this need to be assessed on a case-by-case basis.

Corner

CPC/Qualicare and IPAF held a meeting with GEMS in August at which GEMS agreed to pay for the following codes when you perform a routine pap smear:

- CODE 0190 (consultation) for ICD10 CODE Z12.4 (Encounter for screening for malignant neoplasm of cervix PLUS
- CODE 0202 (Setting of a sterile tray) AND
- Code 0210

We received a confirmation of this in writing from GEMS however, it would appear that these codes are NOT yet being paid for and CPC/Qualicare will investigate this further as a matter of urgency.

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POLMED NETWERK

Code 55500 Polmed Consultation for GP's Annual medical – Preventative Care benefits.

Qualicare meets with Medscheme every month and enquired how many of the 'procedures' below must be done during such a visit? (to qualify for 55500)

We were informed that the items below are the minimum requirements:

- **Blood pressure test**
- **Body mass index (BMI) test**
- **Cholesterol screening**
- **Consultation**
- **Glucose screening**
- **Healthy diet counselling**
- **Waist-to-hip ratio measurement**

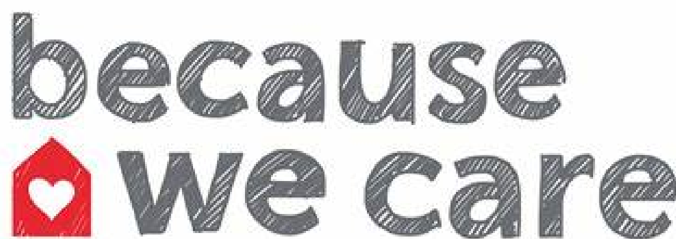
Changes proposed and approved from 2024 Members guide will more clearly indicate what is coved under tariff 55500.

Dear Shareholders and Members,

Please note that when dealing with Discovery Flexicare patients, the following has to be taken into account:

1. The patient has the opportunity to change an allocated network doctor twice per year.
2. If you as a doctor are the third doctor within a year, you will not be paid for your services.

QCC'S



With deepest sympathy from the QCT

With extremely heavy hearts and great sadness we say goodbye to another bright star in our valley's galaxy . . . Dr Merle Malan, you were one in a million. You are already missed immensely. A wonderful mother, doctor, friend, seeker, and a shining example of what goodness we should all aspire to. Rest in Peace, dearest friend, your legend lives on.

Dr Rory Dower, retired general practitioner who had a long and fruitful career in George, passed away on Saturday 5 August at his home at the age of 82.

According to a former colleague of his, Dr Christine Dykman, he was a role model for her when she arrived in George.

"We worked together for 17 years from 2005. I learnt a lot from him. For most of the GPs in George he was someone to look up to and a good example. He will definitely be missed as he has impacted on so many people's lives."

His family said that they have lost a wonderful husband, father and grandfather and a man respected and admired as a doctor and friend. He will be remembered with gratitude and love.

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:

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- 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 R6000.00 per annum)
- 2 Free stationary items worth R150.00 per month in the form of 1 Prescription pad - 100 leaves, 1 Sick certificate pad - 100 leaves and the ability to purchase further stationary at 30% below current market prices.
- Preferential rates on certain Practice management software systems depending on vendor.
- Inclusion into the CPC/Qualicare Mass email service to receive important health care updates.
- Certain personal banking offerings from commercial banks.
- NHI future possibilities for your practice...Watch this space as NHI starts to roll out!!
- Preferred wholesale and facilitation of opening new accounts with them.
- Assistance with registration of an Integrated Pollution and Waste Information System IPWIS off the Western Cape Government.
- Assist with late medical aid payments, claw-backs, and withholds, as well as advice on practice admin and responses to forensic investigations.

Cost of Associate Membership

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

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

Please note that we 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

LOG ONTO YOUR SITES
www.docweb.co.za
www.qualicaredoctors.co.za

Qualicare Electronic Doctor Network.

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

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

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

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

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

*First Name: ______________________________

*Surname: ______________________________

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

____

Professional Body Memberships: ______________________________

____

*HPCSA Number: ______________________________

*Board of HealthCare Funders PCNS Number: ______________________________

DOH Disp Lic Number (if applicable): ______________________________

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

____

Contact Details

*Contact Number: (Practice)______________________________

*Email Address: ______________________________

*Alternative Number: ______________________________

Fax number: ______________________________

Practice Details

*Practice Name: ______________________________

Group PCNS: ______________________________

*Practice Address: ______________________________

____

GPS Location: ______________________________

Qualicare EDN .... continue to page 54

Please also provide:

1. **Photo of yourself** - So that the patient can familiarize themselves with the Dr they are going to see.

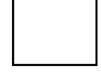
2. **Photo of the outside of the Practice** – So the patient will recognize the correct building and know what to look out for when coming to visit the practice.

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/

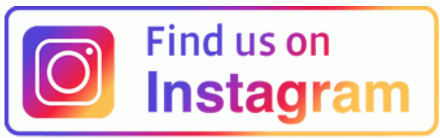
Summary

Reported period	Month Aug 2023				
First visit	01 Aug 2023 - 00:13				
Last visit	31 Aug 2023 - 23:52				
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	**1,737**	**2,119** (1.21 visits/visitor)	**4,071** (1.92 Pages/Visit)	**23,124** (10.91 Hits/Visit)	**2.92 GB** (1446.61 KB/Visit)
Not viewed traffic *			**21,797**	**38,072**	**3.12 GB**

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

www.docweb.co.za

@CPCQualicare



cpc_qualicare

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.

This Newsletter is subject to the provisions of the Protection of Personal Information (POPI) Act (Act 4 of 2013), as well as the General Data Protection Regulations of the European Union (GDPR EU). The content of this site and/or attachments, must be treated with confidentiality and only used in accordance with the purpose for which they are intended.

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THE END