February 2024

QualiCare

Newsletter

Outcomes Measurement and Reporting (OMR), Care Co-ordination and Value Based Care

General Practitioners must take the lead in re-shaping Industry trends.

Outcomes-based primary healthcare is an approach which pivots on positive patient outcomes as the primary goal of healthcare delivery. Primary healthcare must continue to be the bedrock of SA Healthcare in any future healthcare delivery system.

In 1994, CPC/Qualicare coined the mission statement:

"To provide Quality , Accessible , Non Discriminatory healthcare to all citizens of RSA."

Our approach has always been one of patient-centred care, recognizing the importance of tailoring healthcare interventions to individual needs, preferences, and desired health outcomes.

Recently however there has been a growing realisation from doctors , schemes, managed care companies and administrators of the importance of adopting a more **outcomes-based approach.**

By focusing on goals, results and outcomes which are more understandable and relevant to patient's health and measuring those, rather than measuring process measures and extrapolating them backwards to represent our adherence to (or failures of) the goals of Primary healthcare,significant collections of Primary care practitioners have become convinced that this is the *new direction of Primary healthcare*.

Primary Healthcare .....continue to page 3

Inside this issue

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OPEN DAY EVENTS 2024

SAVE THE DATES

We are excited to announce our upcoming CPC/Qualicare Open Day events for 2024.

- **CPD Points Galore!**
- **Fun Atmosphere!**
- **Great Food!**
- **A chance to meet and interact with your colleagues !!**

Cape Town Open Day

Date: 1 June 2024

Venue: Biomedical Research Institution, Opposite P5 parking area on the Tygerberg Medical School Campus.

George Open Day

Date: 17 August 2024

Venue: PINE LODGE, Corner of Knysna Road and Madiba Drive, George East

Worcester Open Day

Date: 19 October 2024

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

It makes far more sense, and achieves far better patient acceptability and thus compliance, which translates more directly into improved specific and measurable patient health outcomes..... the very goal of Primary Health.

I cannot overemphasise that for best results, we need to concentrate our efforts on the outcomes and results **which matter most to patients,** within reason, and match them to international norms and standards.

Key Components of Outcomes-Based Primary Healthcare

- Patient-Centred Focus: This cornerstone of outcomes-based care recognizes patients diverse needs and priorities and allows healthcare providers to work collaboratively with individual patients to identify and define their health goals using skills like active listening and communication, shared decision-making, use of Multi-Disciplinary Teams approaches and a commitment to aligning healthcare interventions with realistic patient values.

- Relevance: Outcomes-based Care places the patient at the centre of healthcare, aiming to achieve positive results that matter most to the patient. This approach emphasizes tailoring care plans to individual patient needs and preferences. These outcomes could include improvements in chronic disease management, enhanced quality of life, reduced hospitalizations, and increased patient satisfaction scores.

- Continuous Quality Improvement. Healthcare providers regularly assess and reassess the effectiveness of their and their patient's interventions, using data to inform and shape decision-making and enhance the patient's quality of care. This iterative process allows for the identification of best practice principles and the refinement of care delivery over time.

- By prioritizing measurable outcomes, healthcare providers are encouraged to continually assess and improve the quality of care leading to identification of best practices and the implementation of sound evidence-based interventions.

- Data-Driven Decision-Making: Robust data collection and analysis is both essential and integral to modern healthcare systems which use it to guide clinical decisions and quality improvement initiatives.

- Care Coordination and Integration: Achieving positive outcomes requires a coordinated and integrated approach to care. This involves collaboration among various healthcare professionals, seamless transitions between healthcare settings, funders and administrators, together with close integration of medical, behavioural, and social care to address the holistic needs of patients.

Primary Healthcare .....continue to page 5

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

Dear Colleagues,

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

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

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

Cost of Associate Membership

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

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

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

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

Advantages of Outcomes-Based Primary Healthcare

- Patient Empowerment: Patients become active participants in their own care, contributing to goal-setting and decision-making. By actively involving patients in the decision-making process and aligning care with their goals, practitioners of outcomes-based care indirectly empower individuals to take control of their own health, resulting in improved patient satisfaction, adherence to treatment plans, and overall positive engagement in healthcare.

- Variability in Patient Goals: Patient-centred outcomes-based care depends on personalized treatment plans. Patients are individuals and a pre set and predetermined funder approach towards outcomes fails to address individual patient preferences. Patients have different goals, needs, wants, desires and stressors. We must adjust our patient centred approach to accommodate them, not them accommodate us or fit into a preconceived treatment plan devised by a big brother, with a built in disincentive for noncompliance.

- Informed Choices: Shared reporting of outcomes empowers patients to make the necessary informed choices about the interventions recommended by their healthcare providers and avoid the inherent paternalistic shackles which are currently built into the Peer review models of various schemes.

- Holistic Care: I suggest that patients would benefit from a more holistic approach that addresses not only their medical needs but also considers social, behavioural, and environmental factors influencing health outcomes.

- Focus on Prevention and Wellness and prevention of wasteful expenditure.

- Outcomes-based care extends beyond the management of illness to include a proactive focus on sickness prevention and wellness promotion. If we can work collaboratively with patients to identify risk factors, implement preventive measures, and promote a healthier lifestyle, we will ultimately reduce the financial burden of chronic diseases.

- Quality Improvement and Innovation: We are hotwired to seek encouragement and appreciation. If we introduce this into our practice of medicine and appreciate and encourage continuous genuine effort no matter how small in our evaluation of patient outcomes, we can steadily support improvement and personal patient innovation in their quest for quality health outcomes. Doctors, by nature of their training will research, inquire, stay abreast of change and do everything possible to assist with positive patient outcomes. Is this not the genesis of driving evidence-based, outcomes-based value medicine?

- Accountability and Transparency: Reporting on outcomes in general should be a drawcard for any Primary Healthcare practice. Good communication not only with your immediate patients, but to the general patient population by way of:

►anonymised pamphlets,
►charts and graphics,
►blogs,
►websites and
►posts on a variety of diseases,
►active support of specific days like World Diabetes Day etc,
►offering free Blood glucose estimations one day a month
►Satisfaction surveys of your practice

are all a patient public service, generate significant tranches of data and can serve as potent indicators of the perception of the general patient population in your area. They are of huge interest to the public at large, as well as compliment your practices adoption of outcomes-based care to other healthcare providers and organizations.

Patient populations from state, regional and private individuals in the community are thus supplied with important stats to support informed choices about their care.

Boland Bank Building, 5th Floor, Suite 501, 18 Lower Burg Street, Cape Town, 8000
PO Box 15633, Vlaeberg 8018
Tel: (021) 426 4777 Fax: (021) 426 5502
E-mail: tony@cpcqualicare.co.za
Website: www.docweb.co.za

Company Announcement

13 December 2023

Dear Shareholders and Members,

Announcement of General Manager for CPC/Qualicare

I am pleased to share some exciting news with all of you. As Qualicare continue to evolve and grow, it is my pleasure to introduce our new General Manager, John-Paul Valentyn.

John-Paul brings a wealth of experience and expertise to this role, and we are confident that his contribution will significantly enhance the success and innovation of our company. In this position, JP, will be instrumental in driving our strategic initiatives, fostering collaboration across key areas, and ensuring the continued excellence of our operations.

John-Paul has a long history with CPC Qualicare spanning over more than 2 decades. His commitment and care towards the General Practitioner stretched over many years. In his previous capacity in various leadership roles in AstraZeneca Pharmaceuticals namely Key Account Management, Market Access Senior Manager & his recent role as Sales Manager in the Western Cape, he played a pivotal role in driving investment in the training and upskilling of HCP's in pursuance of improvement of patient outcomes. During the COVID pandemic, especially, he guide Qualicare & support our company to become the 1st IPA to host an Open Day virtually. This event set the benchmark for virtual and hybrid excellence in the IPA environment which was of benefit to the IPA's, the HCP's and a multitude of pharma companies.

John-Paul will commence his new role on the 1st March 2024.

Please join me in welcoming John-Paul to his coming new role as General Manager in Quarter 1, 2024. We are confident that, with his skills and dedication, our company will reach new heights in 2024 & beyond.

Yours sincerely,

Dr. AD Behrman CEO CPC/Qualicare & Dr. Sol Lison Chairman CPC/Qualicare

CPC DOCTOR'S FUND (PTY) LTD T/A QUALICARE
Directors: Dr S Lison, Dr AD Behrman
Reg No 95/03533/07 (Vat No 470175882)

Enhanced reimbursements for improved outcomes:

Outcomes-based care not only promotes transparency in healthcare delivery,it also enhances the patient doctor relationship, and together we form a responsible unit to be rewarded for the results achieved or accountable and remotivated for poor results.

This is unlike current models which concentrate on process indicators and financial disincentives for noncompliance with performing the relevant tests required by the funders which may mean nothing to the patients and are resented as using up their limited benefits.

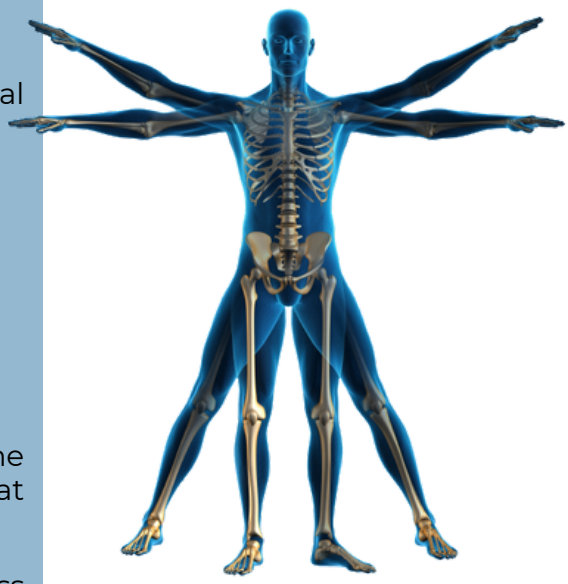
This model is also conducive to managing the health of populations by addressing the underlying factors that contribute to specific outcomes.

Challenges in Implementing Outcomes-Based Primary Healthcare

- Data Challenges: The raw patient data, when de-identified, comes from ***our*** PHC surgeries, and the path labs, radiologists and pharmacies to which we refer patients.
- Currently we do not have systems to collate, correlate and standardise our findings and these reside with the payors of the services within their considerable databanks, who claim them as their IP and mine them, from whence policy is dictated. This paternalistic approach falls far short of outcomes based and value based care and should be carefully re evaluated and replaced.
- Funders utilise mainly process measures to feed back to providers and to evaluate their performance. These are accepted, often without verification and are seldom challenged by the Family Practitioner. They are often expressed against unverified denominators, and are tied to enhanced remuneration or withhold of such enhanced payments, the emphasis being on compliance with disparate criteria which vary from funder to funder, with a strong cost saving component and not necessarily on positive value outcomes to the patients.
- Compliance with funder devised formularies, themselves frequently dictated by price of an older class medication, and linked to a variety of non-transparent, non-health related arrangements with the pharma industry, does not necessarily augur well for good patient outcomes .
- Risk of “Cherry Picking” or "Cream Skimming": There is also a risk that healthcare providers may prioritise their focus on patients with better prognoses to achieve better outcomes, potentially neglecting those with more complex or challenging conditions, ushering in an ignoble element of unfair physician selection bordering on discrimination and negating the ethos of true outcomes value based care for all.
- HPCSA and their CPD requirement needs to emphasize this new avenue of thought.
- Interdisciplinary Collaboration: Multidisciplinary teams are the cornerstone which supports successful outcomes based and value based medicine. When you are not sure, consult with a colleague, refer to your MDT, send, receive and share your and their reports with the others in the MDT. A functional MDT should be filing all the common reports in one place in the cloud where they are readily accessible to any member of the MDT.
- Intercollegial interdisciplinary team collaboration is the lynchpin in the cohesion of an MDT in assuring outcomes-based medicine succeeds.

Primary Healthcare.....continue to page 8

- **Final comments :**



► We must all be vigilant regarding maintaining our Ethical values of:

- ✔Beneficence ,
- ✔Non Maleficence,
- ✔Autonomy,
- ✔Justice and
- ✔Ubuntu.

►Reduce our emphasis on Process Measures:

►Effective outcomes-based care has to live in harmony with the relevant process measures which, of course, are all that we have at present.

►The new thinking however should gradually replace process measures and concentrate more on outcomes based, patient centred care. We must however not neglect the essential importance of standardised process measures. They must however not dominate the patient experience, going forward, but rather complement it.

►We have to retrain, retool and realign educational modules at our teaching institutions, HPCSA, Funders and their brokers, patients, and most importantly at Board of Trustees of schemes and the advice they receive from their actuaries.

►It won't be like switching on an old-fashioned light switch, but rather using a more sophisticated dimmer switch to fade out the process indicators and amplify patient based value outcomes, which will highlight a new common sense approach.

►It will therefore not be like switching on an old-fashioned light switch, but rather using a more sophisticated dimmer switch to fade out the process indicators and illuminate patient based outcomes, which will highlight a new common sense approach.

Dr Tony Behrman CEO CPC/Qualicare.

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South Africa has a dire shortage of doctors

South Africa's healthcare system is facing a dire shortage of doctors, particularly in the state-run public healthcare system, which has run out of money to employ new doctors who are increasingly turning to the private sector for employment.

This is feedback from the chairperson of the South African Medical Association (SAMA), Dr Mvuyisi Mzukwa, who told Newzroom Afrika that some doctors even leave the country as there are no jobs here for them.

Mzukwa's comments come on the back of a revelation that 800 qualified doctors are not being employed in public health posts because of a shortage of funds.

He said the problem is rooted in poor planning and not only in cuts to the Department of Health's budget.

As the public sector provides the majority of healthcare services in the country, there should be a clear understanding of the resources the department needs and how this may change in the future. This planning has not happened.

Mzukwa added that the government is concealing the number of openings in the public sector as it is not replacing doctors who retire. It is rather erasing the posts held by former doctors.

"In the state system, there is a dire shortage of healthcare workers, especially doctors. In rural areas, the shortage is particularly dire," he said.

The shortage of healthcare workers extended from nurses to highly trained specialists whom the public sector is also unable to employ for various reasons.

Mzukwa said many of these specialists end up working in the private sector, leaving the country, or remaining in their current posts rather than filling a specialised role.

"The problem is you are leaving the public healthcare sector in a dire state because there is a shortage of staff, and those that remain are overworked," he explained.

This, in turn, has a chilling effect on future doctors who are wary of working in the state-run system because of the workload and deteriorating work conditions.

Shortage of doctors .....continue to page 12

CNS

A calming touch

Introducing CLOBAZAM ADCO

Indicated for the treatment of anxiety in neurotic patients, for pre-operative medication, and it may be effective in relieving the acute symptoms of alcohol withdrawal syndrome[1]

May be used as an adjuvant in epilepsy*[1]

- Unlike other benzodiazepines, **CLOBAZAM ADCO** has less sedative effects[2]
- Mild to moderate adverse events[2]
- Cost saving of 15 % versus originator[3]

NEW

Clobazam

Clobazam ADCO

*The dosage of CLOBAZAM ADCO should be determined by monitoring the EEG and plasma levels of the other medicines.[1]

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

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

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

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202308011030334Z. August 2023.

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The implementation of National Health Insurance (NHI) will make the problem worse as it will require the government to rapidly expand the capacity of the existing healthcare system and employ more people.

The NHI, as currently outlined, will not increase the funds available to train and hire new doctors but will only pay for services on behalf of South Africans. The capacity of the system will not be improved.

Ultimately, the NHI is only a funding model and not a piece of legislation that will reform healthcare in South Africa.

Trade union Solidarity comments

Trade union Solidarity said the latest data is in stark contrast to Deputy Director General of Health Dr Nicholas Crisp's statements.

Crisp said that there was no shortage of doctors because the Department of Health "at this stage is struggling to give work to all the doctors qualified in this country."
He is also a prominent campaigner for the implementation of the National Health Insurance (NHI).

"Although he denies that there is a shortage of doctors in South Africa, there is some contradicting evidence," Solidarity said.

"Up to a thousand frustrated junior doctors are asking for solutions on social media and elsewhere to their frustration with the problems regarding their placement for community service and jobs."

Theuns du Buisson, economic researcher at the Solidarity Research Institute (SRI), said the Department of Health is concealing the real reason for the failure to place doctors.
"The core of the problem lies in a serious shortage of funds, and Dr Crisp chooses to ignore it," Du Buisson said.

"The Department of Health is experiencing serious challenges financially and with management, leading to an inability to place healthcare graduates."
He said the problem extends beyond just the immediate issue of unemployment and career frustration among doctors.

"This has an impact on access to healthcare for millions of South Africans, especially in communities where doctors in their community service years are the only doctors available," he said.

Du Buisson added that many doctors have already indicated that they will emigrate under the new proposed NHI system.

Solidarity appealed to the government to urgently put structures in place to get doctors placed.
"We hope that this state of affairs will be a wake-up call to the government to abandon its plans with the NHI and its much larger structures," it said

When staying-power counts

LASTS UP TO **36h**[1,2]

TADALAFIL ADCO for the treatment of ED[1]

- Demonstrates improvement in EF for up to 36 hours post-dose[1,2]
- Tadalafil improves psychological outcomes[2]
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Tadalafil Adco

Tadalafil 5 mg/20 mg tablets

The patient's choice for ED[2*]

*In a meta-analysis comparing tadalafil with sildenafil for the treatment of ED.

ED – erectile dysfunction; EF – erectile function

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

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

S4 TADALAFIL 5 mg ADCO. Each film-coated tablet contains 5 mg tadalafil. Reg No.: 52/7.1.5/0084.080. S4 TADALAFIL 20 mg ADCO. Each film-coated tablet contains 20 mg tadalafil. Reg No.: 52/7.1.5/0085.081.

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Aan ALLE inwoners, praktyke & pasiënte wat geraak word deur die erge brande in die Wes-Kaap.

CPC/Qualicare wil ons innige meegevoel betuig met die verwoestende brande wat u as gemeenskap in die gesig staar/ gestaar het.

Ons kan nie die pyn en hartseer wat u tans ervaar, ten volle begryp nie, aangesien u sien hoe hektaar plantegroei deur die onbeheerbare vlamme verteer word. Weet asseblief dat ons gedagtes by u is .

Ons is gevul met bewondering vir die manier waarop julle as gemeenskap bymekaarkom om mekaar te ondersteun en by te staan. Dit demonstreer die krag van eenheid en die strewe om hierdie teëspoed as 'n kollektiewe krag te herbou en te oorkom.

CPC/Qualicare wil ook ons innige waardering en dank betuig aan die brandbestryders, noodpersoneel en vrywilligers wat onverpoosd werk om die brande in bedwang te bring en die veiligheid van almal wat geraak word, te verseker. Hulle dapperheid en onbaatsugtigheid in die aangesig van sulke gevaar is merkwaardig en verdien die grootste lof.

Namate die dae in weke verander en die vlamme bedaar, hoop ons dat u vertroosting vind in die krag van u gemeenskap en die uitstorting van liefde en ondersteuning van naby en vêr.

Dr. Tony Behrman, Dr. Solly Lison en Qualicare personeel.

THE PATHCARE NEWS

RESPIRATORY PATHOGEN STATISTICS: 2023 SUMMARY

This report is a summary of the results obtained from various molecular respiratory panels performed across PathCare laboratories during 2023, with additional data from December 2023. As with the monthly respiratory pathogen reports, the data is dependent on submission of samples by clinicians and therefore may not be representative of the general population but is intended to identify trends in the circulation of these viruses which may be of clinical relevance.

INFLUENZA, RESPIRATORY SYNCYTIAL VIRUS AND SARS-COV-2

- Respiratory syncytial virus (RSV) and influenza A virus showed typical seasonal circulation, with an early RSV peak followed by an increase in influenza A during the winter months (Figure 1). This correlated with the RSV and influenza seasons as defined by the National Institute for Communicable Diseases (NICD) with RSV season running from week 6 (week starting 6 February) to week 21 (week starting 22 May) and influenza from week 17 (week starting 24 April) until week 27 (week starting 10 July).
- The influenza A season was predominantly due to influenza A H3N2 infections (95% of influenza A isolates for which typing was available), with sporadic cases of influenza A H1N1 (<5% of influenza A isolates for which typing was available).
- Although some cases of influenza B were detected from approximately week 35 onwards, the positivity rates did not reach the epidemic threshold and remained below 10% throughout 2023.
- The highest SARS-CoV-2 detection rates were noted in weeks 6 – 9 (22 – 25%) and remained below 20% for the rest of the year.

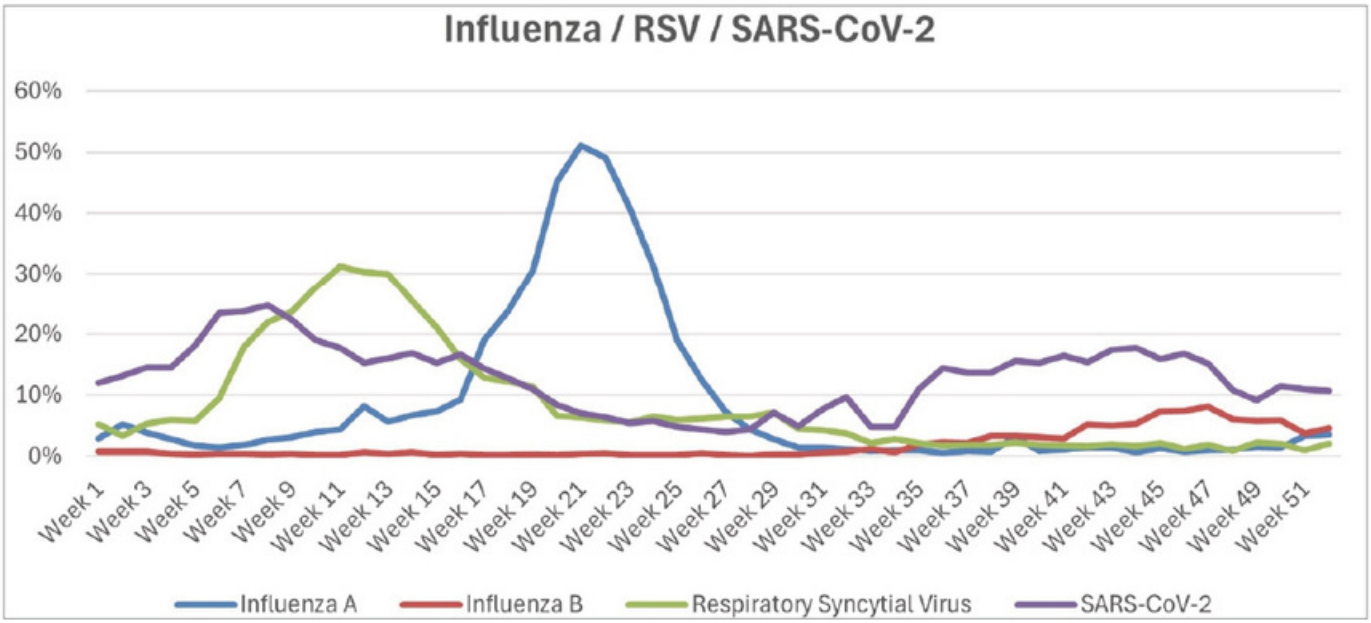


Figure 1: Percentage positivity of influenza A, influenza B, respiratory syncytial virus and SARS-CoV-2 by epi-week for 2023.

- The age distribution of positive samples (Figure 2) was similar to that observed in 2022. SARS-CoV-2 positive samples were mostly from adult patients, while RSV was detected predominantly in children under 5 years of age. Influenza A and the sporadic cases of influenza B were detected more broadly across all age ranges.

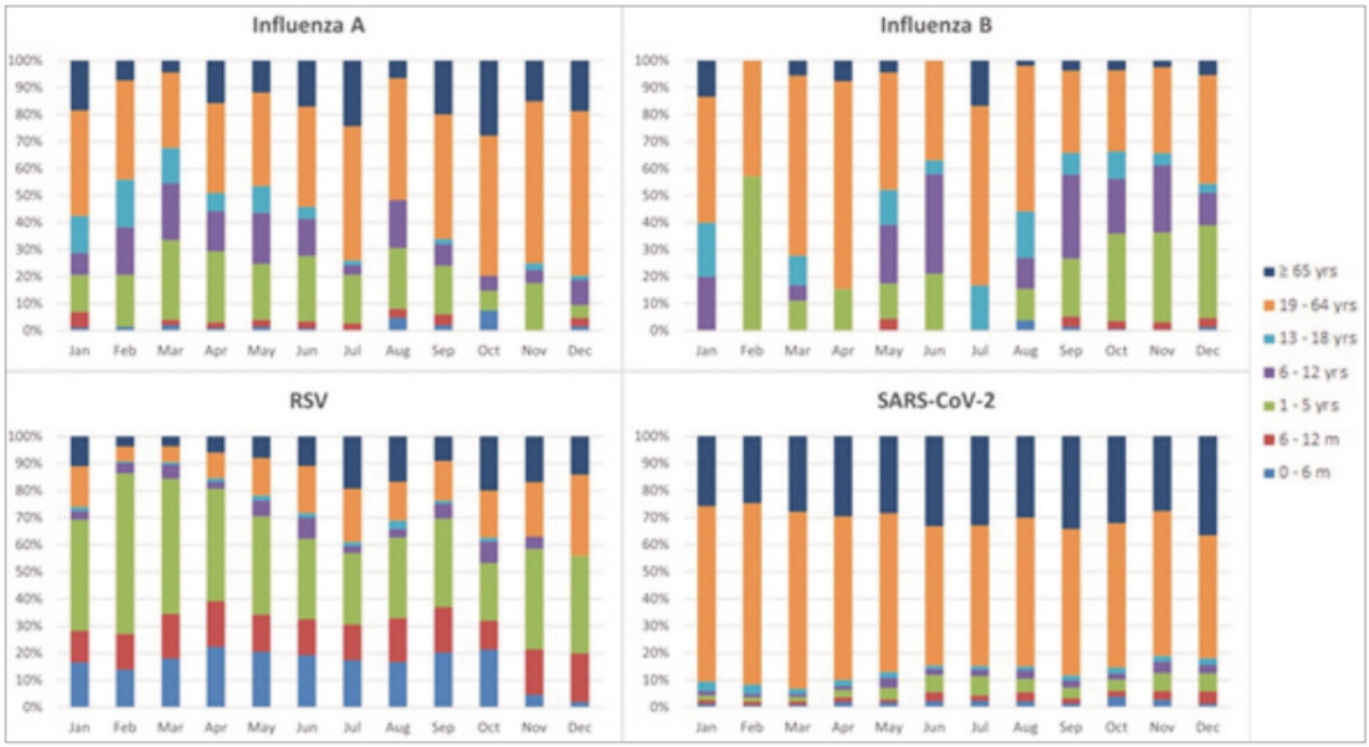


Figure 2: Age distribution of positive samples by month for influenza A, influenza B, respiratory syncytial virus and SARS-CoV-2 in 2023.

CORONAVIRUSES (EXCLUDING SARS-COV-2)

- The detection rate for the endemic coronaviruses (229E, HKU1, NL63 and OC43) was highest during January and February due to an increase in the NL63 detection rate and increased again from approximately June until mid-November due to increased detection of OC43.

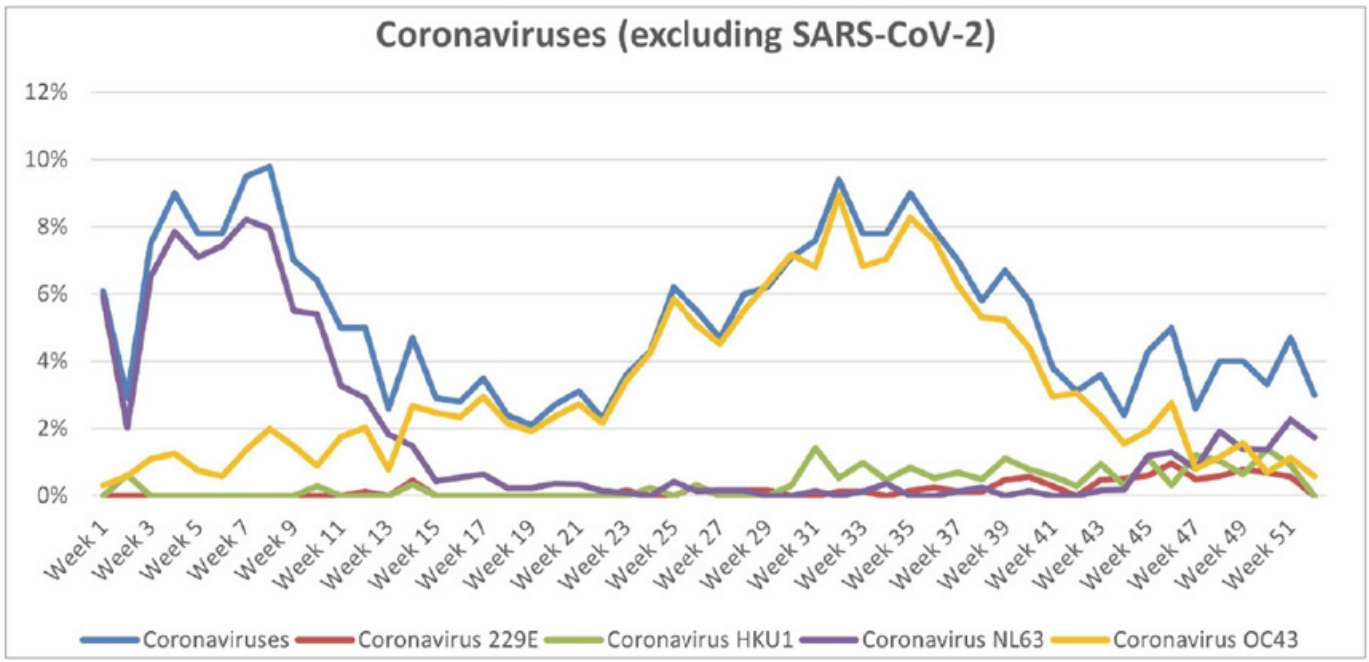


Figure 3: Percentage positivity of endemic coronaviruses by epi-week for 2023.

PARAINFLUENZA VIRUSES

- During the first half of 2023, parainfluenza detection rates remained below 10% with sporadic detections of all four parainfluenza types. In the second half of the year, increased parainfluenza virus detection rates corresponded to an increase in parainfluenza type 3 positivity (percentage positive range 3-14%) and to a lesser extent due to parainfluenza type 1 (percentage positive range 2-5%).

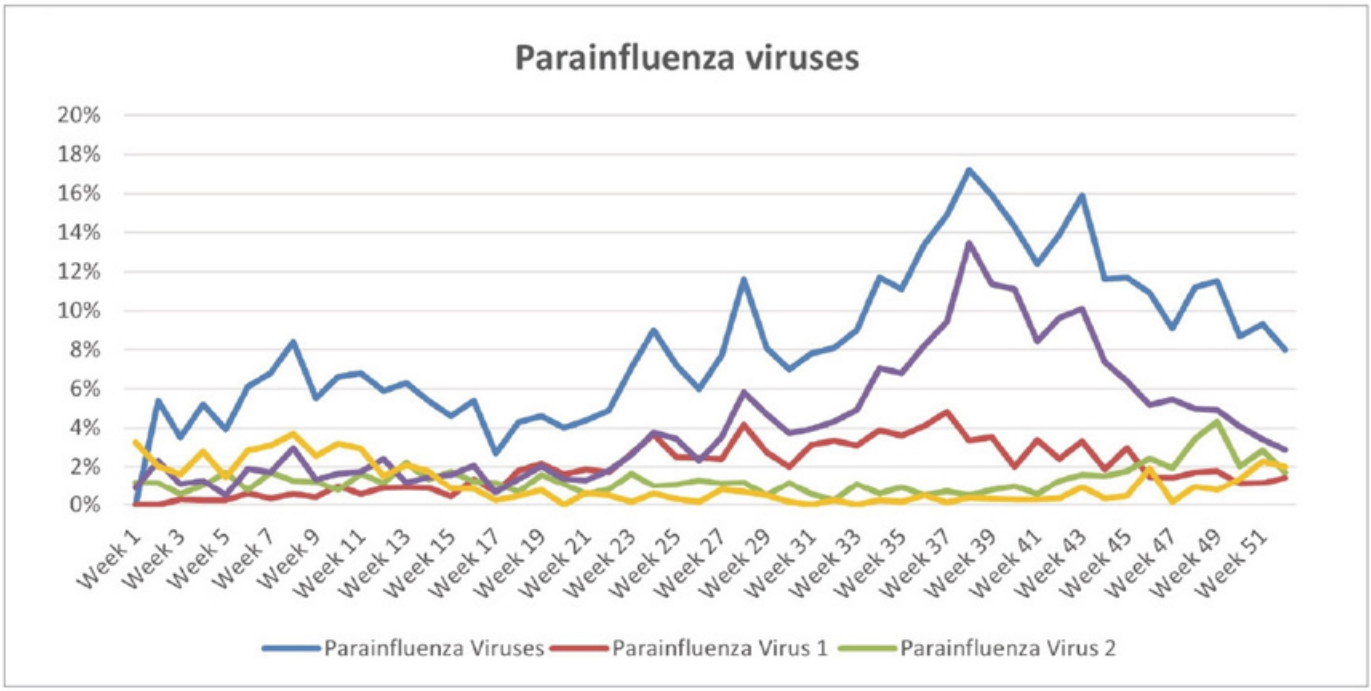


Figure 4: Percentage positivity of parainfluenza viruses by epi-week for 2023.

ADENOVIRUS, BOCAVIRUS, HUMAN METAPNEUMOVIRUS AND HUMAN RHINO/ENTEROVIRUS

- Adenovirus and human rhino/enterovirus showed year-round circulation as is typically described globally.

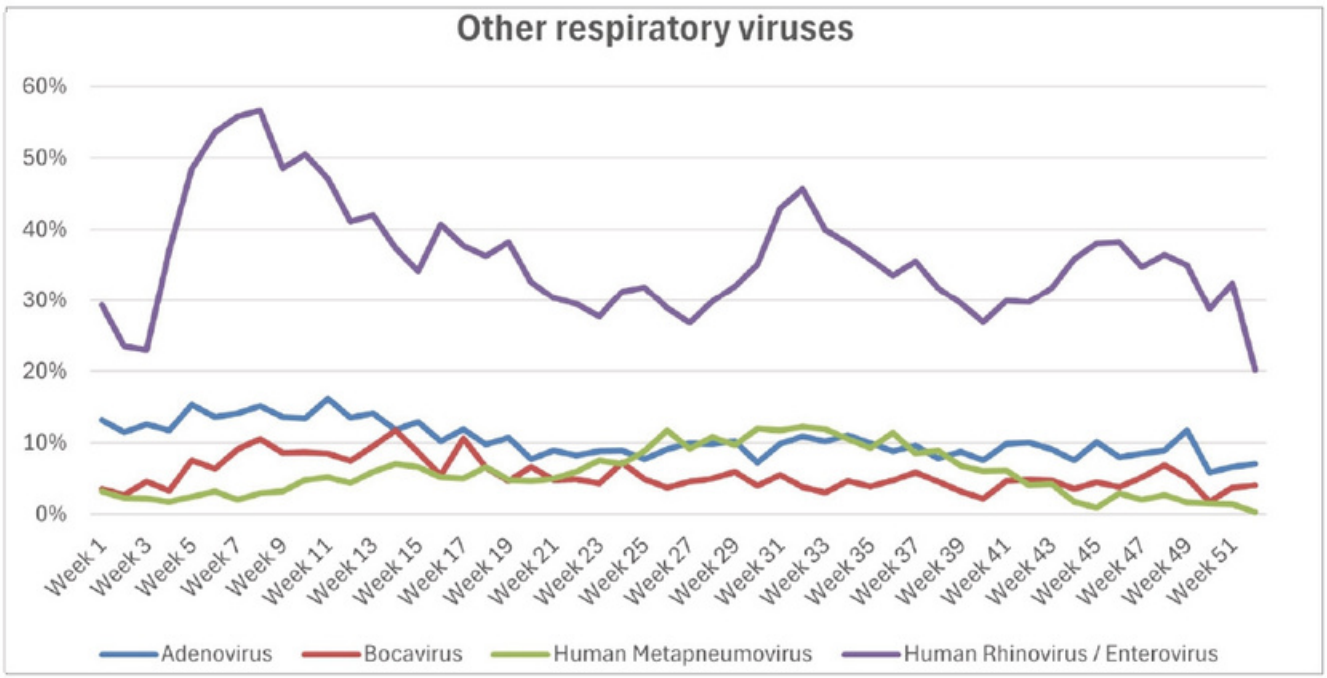


Figure 5: Percentage positivity of adenovirus, bocavirus, human metapneumovirus and human rhinovirus/enterovirus by epi-week for 2023.

ATYPICAL BACTERIA

- *Mycoplasma pneumoniae* was the most commonly detected atypical bacterial pathogen throughout 2023, persisting at rates of 4% and above since March. Interestingly increased numbers of *M. pneumoniae* cases have been noted in many countries globally during 2023, probably reflecting increased circulation of this pathogen after the relaxation of COVID non-pharmaceutical measures which had halted transmission during the pandemic.
- *Bordetella pertussis* detection rates remain between 1% - 2% throughout the year which is gratifying since the disease is largely preventable by vaccination.
- Sporadic cases of *Legionella pneumophila* were detected throughout 2023, with a single case reported in December, from Gauteng. Please note that the inconsistent increases in detection rates are related to the relatively small number of samples submitted for testing. Legionella is not included in the Biofire Respiratory Panel. For suspected cases please submit an appropriate lower respiratory tract sample and request the Respiratory Bacterial Panel or upon specialist recommendation, the Biofire Pneumonia Panel.
- *Chlamydophila pneumoniae* was rarely detected throughout the year (< 2%).

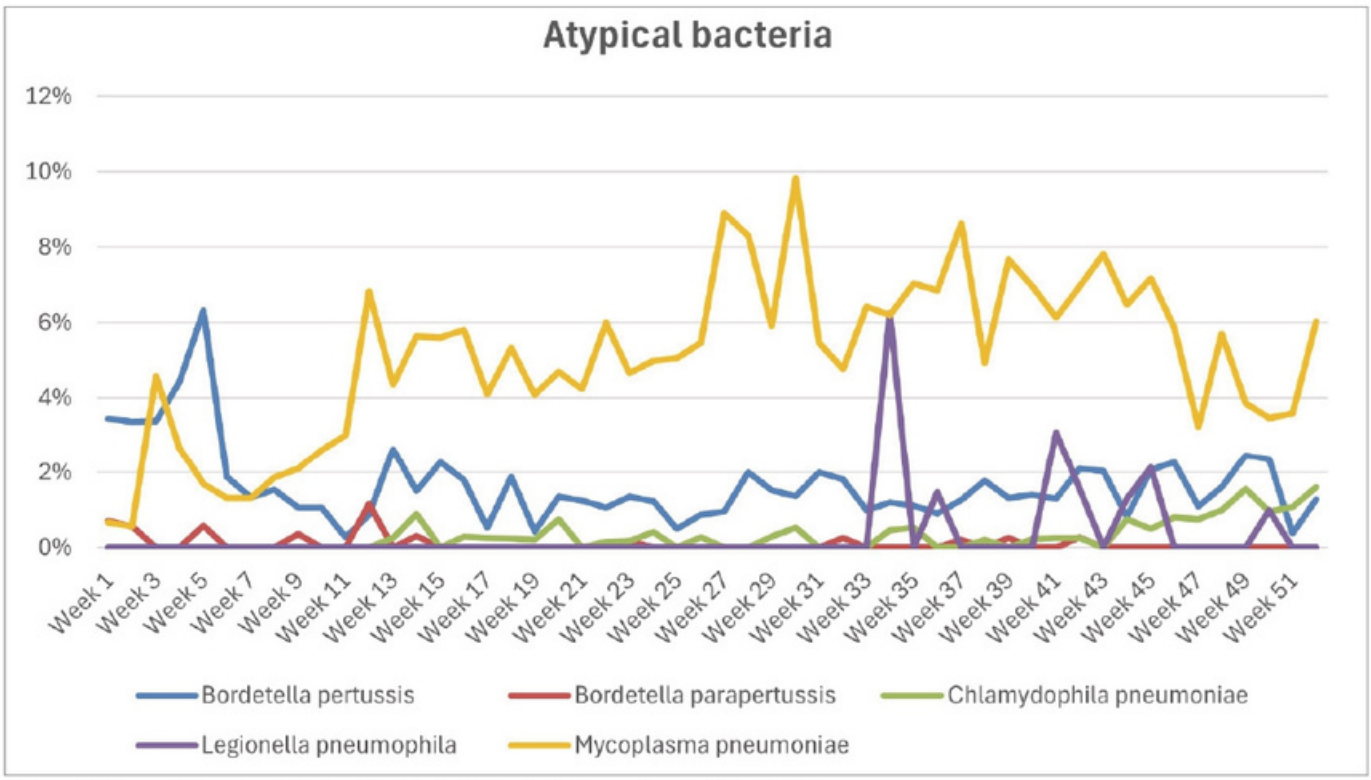


Figure 6: Percentage positivity of atypical bacteria by epi-week for 2023.

PICTURE OF COVID-19 IN EUROPE IS COMPLEX

"COVID is here to stay," emphasized World Health Organization (WHO) Regional Director for Europe, Hans Kluge, MD, at a press briefing on January 16, 2024. He stressed the need for continuing vigilance and efforts to keep the disease at the top of the political and healthcare agendas, while attention may be drifting to other major global events.

The WHO estimated that COVID-19 vaccines have saved at least 1.4 million lives in the WHO European Region, which encompasses 53 countries across a broad geographical area including the European Union (EU) and countries like Russia and Israel. Kluge said that at present, COVID-19 rates "remain elevated but are decreasing." However, he emphasized that the region is seeing widespread circulation of other respiratory viruses, including influenza, respiratory syncytial virus, and measles. The WHO was concerned that health services should prepare for an upsurge in the full range of respiratory virus hospitalizations in the next few weeks.

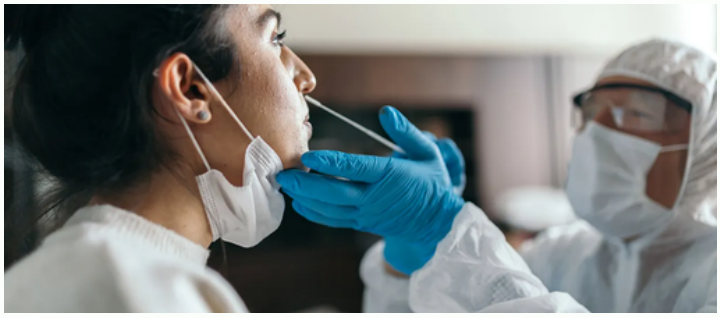
Kluge said that the unpredictable nature of the SARS-CoV-2 virus means that the emergence of new variants could cause the current situation to rapidly worsen.

A Complex Picture

Edoardo Colzani, MD, the Principal Expert on Respiratory Viruses at the European Centre for Disease Prevention and Control (ECDC), told Medscape Medical News that in the EU and European Economic Area, "Countries report a mix of increasing and decreasing trends in SARS-CoV-2 activity, COVID-19 hospitalizations, and ICU admissions and deaths, with severe outcomes predominantly among those aged 65 years and above."

The ECDC monitored the results of COVID-19 tests in selected sentinel sites chosen to give a representative sample. The percentage of positive tests in primary care sites increased from week 44 to week 49 of 2023 but fell since week 50.

COVID-19 in Europe Is Complex .....continue to page 20



Colzani said that many countries also conduct testing at non-sentinel sites, such as hospitals, schools, primary care facilities, laboratories, and nursing homes. "At the EU and EEA level, SARS-CoV-2 detections and testing in non-sentinel data were similar to those reported for sentinel data, with most countries reporting decreasing trends. However, in some countries, SARS-CoV-2 positivity and detections in non-sentinel data are notably increasing, especially in those aged 65 years and above," he explained.

Despite a decreasing trend in COVID-19 across Europe overall, data from the WHO reported an increasing trend in SARS-CoV-2 positivity in four EU reporting countries in the second week of January: Poland, Portugal, Switzerland, and Slovakia.

In terms of disease severity, Colzani said, "We wouldn't go as far as saying that there is declining severity, but surely it's not increasing...But if [vaccination] is not kept up to date, then we may see an increase in severity due to waning immunity, particularly among groups at risk."

The data available collectively from the ECDC and WHO revealed a complex picture of increasing and decreasing trends, covering rates of positive testing, hospital admissions, intensive care unit (ICU) admissions, and COVID-19–associated deaths. The values were changing significantly from week to week.

In terms of death rates, the WHO stated that although levels remained relatively low in the second week of January, Malta reported a marked increase in COVID-19 death rates in people aged 65 years and older, while 10 of the 14 countries reporting age-specific death data documented a marked decrease.

Challenges, Lessons, and Plans

"Member States should be ready for the possible need to increase emergency department and ICU capacity, in terms of adequate staffing and bed capacity, for both adult and pediatric hospitals," said Colzani. "Hospital administrators and managers should ensure that resources, such as medical and nursing staff and equipment, are also available."

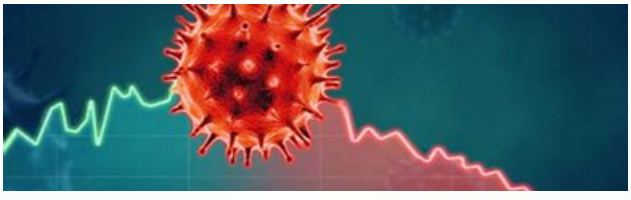
As the virus continues to evolve, the ECDC view, generally shared by the WHO, is that there are currently no new variants of concern, but there are some variants of interest that are being closely monitored. "JN.1, which is a sub-lineage of the BA.2.86 variant, has been particularly increasing in proportion recently, but without so far causing a visible impact on the epidemiological indicators," said Colzani.

The prevalence of the diverse range of issues characterized as long COVID is another major aspect of the disease. The WHO estimated that 36 million people across the WHO European region may have developed long COVID over the first 3 years of the pandemic.

Several speakers at the WHO briefing highlighted lessons learned from the pandemic to help prepare for future ones, including the importance of regional resilience, with nations and regions needing to become self-sustainable in the manufacturing of medical and other supplies and in conducting clinical trials.

Looking to the future, Catherine Smallwood, MD, COVID-19 Incident Manager of WHO/Europe, told the press briefing, "We are working...in the European region and beyond to revise and update pandemic plans [to ensure] that what we've experienced in the last pandemic can be documented and included in the pandemic plan for the next one."

Hans Kluge concluded, "...It's so important [to get] an international agreement, a pandemic accord...to tackle some issues like much quicker exchange of information, of data on clinical trials, and of sharing also the different medical countermeasures."



JUST A LITTLE Reminder

URGENT REMINDER - Payment of Annual Renewal Fees to BHF (PCNS)

Dear CPC Shareholders and Members,

You are reminded that the **Annual Fee(s) for renewal with BHF for your PCNS number(s), (practice coding numbering system) becomes due by the 31st of March 2024**
The standard fee for a solo practice number (pr. no) is **R396.00**
Remember: You need to pay your individual pr. no. as wéll as the group pr. no. (if applicable)
PLEASE KEEP YOUR RECEIPTS OF PAYMENT & POSTING

Please use your practice number (ónly the last 7 digits) as reference for payment

To view your balance or make payment please visit BHF's website on: https://www.pcns.co.za/Payment/CheckBalance

(you might have a credit, etc.?)

Alternatively, PCNS also states that "you can make payment onto the following banking details:

Nedbank account holders only: We are now a Bank Approved Beneficiary with Nedbank so in order to pay please add us as a beneficiary first by selecting: **- PCNS Renewals** for existing practice numbers **(your 7-digit practice number is required as reference)**

FNB clients: We are a public registered business as PCNS, and you can use your online banking and or banking app to pay for your practice renewal.

Other bank transfers: Bank: NEDBANK, Account name: PCNS Branch: Rosebank, Branch Code: 197705, Account Number: 1958 5185 30 (cheque account) **Ref: Pr. Nr (last 7 digits)**

E-mail proof of payment to: pcnsfinance@bhfglobal.com **(Pr. No in subject line)**

Contact Details: 011 537 0299 / 087 210 0500 "

PCNS
PRACTICE CODE NUMBERING SYSTEM

HEALTH SERVICE APPLICATION	NON-REFUNDABLE APPLICATION FEES	ANNUAL RENEWAL FEE	NON-REFUNDABLE ACHANGE OF PRACTICE TYPE	REINSTATEMENT
SOLUS PRACTICE HPCSA	**R761.00**	**R396.00**	**R781.00** Plus, any outstanding balance on existing PCN	**R718.00**

FIX DAILY IRRITANTS TO REDUCE CLINICIAN BURNOUT, KLAS SAYS

Arch Collaborative researchers say organizations can keep post-pandemic burnout from worsening, if they intervene early on and don't dismiss clinical staffs' "small concerns."

The KLAS Arch Collaborative wanted to learn more about how doctor and nurse burnout has evolved since the pandemic, and what hospitals and health systems can do to address it. So it conducted a provider experience survey focused on clinicians' use of electronic health records between January 2022 and August 2023.

WHY IT MATTERS

KLAS says the data in its study, Understanding & Addressing Trends in Physician & Nurse Burnout 2024, indicates that burnout rates are slightly decreasing among doctors and nurses, but are still above pre-pandemic levels.

Of the 20,229 physicians and 32,782 nurses KLAS surveyed over the 20-month period, they cited several contributing factors.

To alleviate burnout, doctors and nurses want improved staffing levels, better alignment with leaders and EHR efficiency, while nurses want better compensation.

"Physicians who are starting to feel burned out often cite no control over workload and a chaotic work environment as contributors," said KLAS researchers in the new report.

"In contrast, those who are completely burned out cite no control over workload, lack of autonomy and lack of shared values with leadership."

Staffing is still a key issue for nurses, according to the study, but full-blown nurse burnout mirrors that of doctors, according to the study.

"Nurses who are starting to feel burned out most often cite staffing, while those who are completely burned out cite similar contributors to physicians who are completely burned out," the researchers said.

While the perception that their EHRs inhibit quality also had an impact on their burnout, the good news is that after improving staffing and better aligning leadership to their concerns, "Health systems can focus on improving efficiency" irritants that can build clinicians' frustration to an overwhelming point, they added. Researchers said the KLAS data showed that "trust flourishes and burnout decreases" when there is a partnership with IT team who reduce EHR and other daily technological inefficiencies that can frustrate clinicians.

In one member example included in the report, the State University of New York's Upstate Medical University, a member of the Arch Collaborative, was able to boost efficiency for clinicians by having their chief wellness officer lead a training program that reduced after-hours documentation by 10%.

Reduce clinician burnout .....continue to page 23

Reduce clinician burnout .....continue from page 22

THE LARGER TREND

The KLAS researchers note that since 2018, burnout rates have increased across the healthcare workforce, though they started to level off again in late 2022.

While staffing shortages are a top contributor in this new study, those who are starting to feel burned out cite efficiency-related issues as reasons, and that means there is an opportunity to prevent excessive burnout by increasing EHR efficiency early on.

In October, KLAS released data from a previous study that validated vendor offerings and firms that work better for providers.

KLAS evaluated 67 healthcare organizations opinions on EHR service and product offerings to learn which offered efficiencies that transformed clinical programs.

"It is one of the metrics with which clinical staff are least satisfied – only 46% of respondents agree their EHR enables efficiency," the KLAS researchers said about their clinical EHR efficiency report.

ON THE RECORD

"Regarding EHR efficiency, physicians (and some nurses) report they are increasingly doing more work with fewer resources," KLAS researchers noted in the report.

"If organizations are unable to hire more staff to distribute the workload, they can instead ensure clinicians receive ample EHR education and that their workflows are optimized." - 32

DOPAMINE FASTING: SOME MDS ARE PRESCRIBING IT. SHOULD YOU?

SIt's an appealing concept: Stop addictive behaviors for a while — think social media, video games, gambling, porn, junk food, drugs, alcohol (dry January, anyone?) — to reset your brain's reward circuitry, so you can feel great minus the bad habits.

People call it dopamine fasting, abstinence sampling, or dopamine detox. But is shutting off the rush of that feel-good neurotransmitter really the key to kicking addictions?

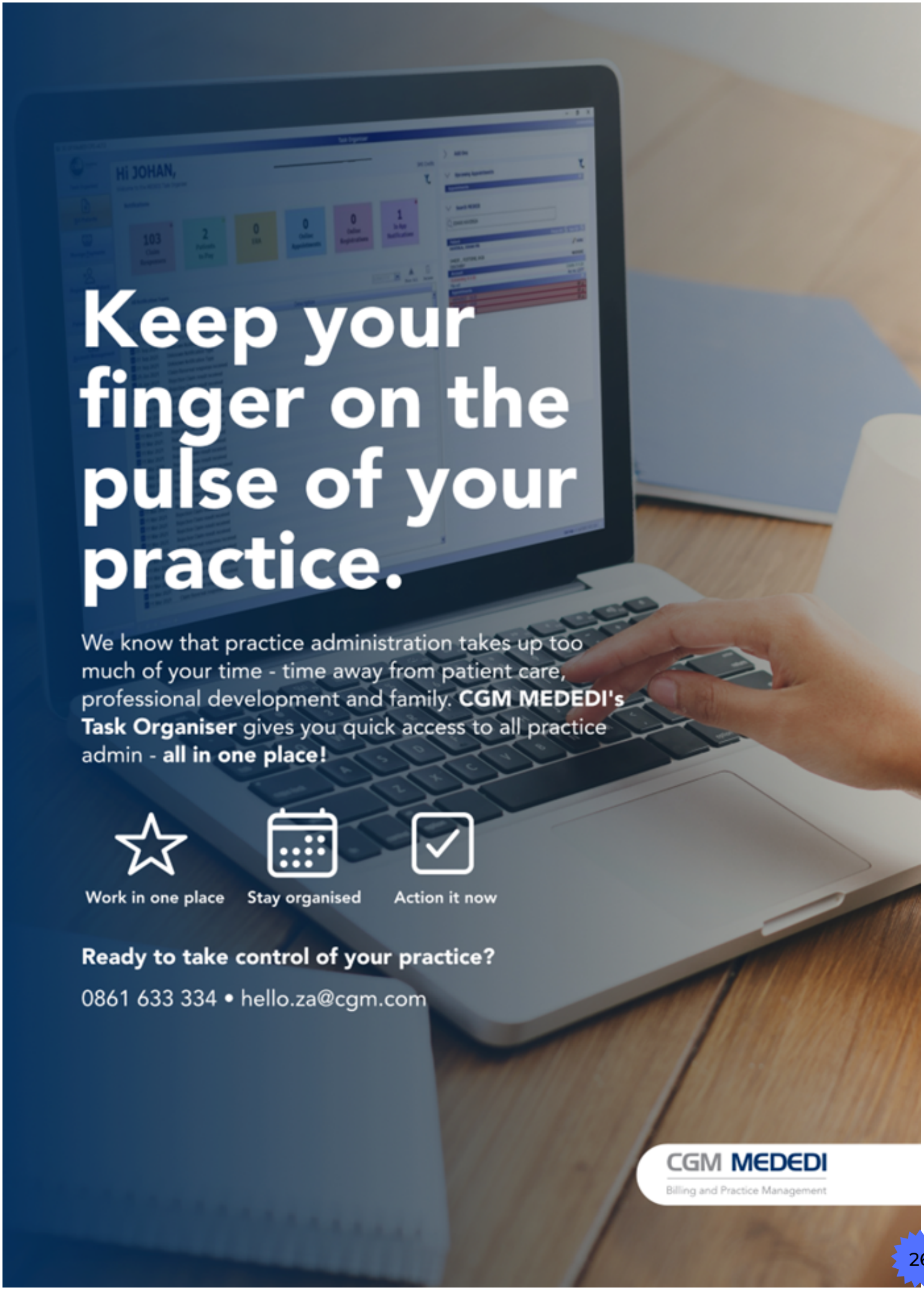
TikTok influencers and Silicon Valley execs seem to think so. But so do some physicians.

Prominent among the proponents is Anna Lembke, MD, professor of psychiatry at Stanford University School of Medicine and chief of the Stanford Addiction Medicine Dual Diagnosis Clinic. There, the dopamine fast is an early intervention framework for many of her patients.
"What we have seen in those patients is that not only does craving begin to subside in about 4 weeks, but that mood and anxiety and sleep and all these other parameters and markers of good mental health also improve," Lembke said.

Any clinician, regardless of background, can adopt this framework, the Dopamine Nation author said during her talk at the American College of Lifestyle Medicine (ACLM) conference last fall. "There is this idea in medicine that we have to leave addiction to the Betty Ford Clinic or to an addiction psychiatrist," she told the gathering. "But there's so much that we can do, no matter what our training and no matter our treatment setting."

But is dopamine fasting right for your patients? Some experts said it's an oversimplified or even dangerous approach. Here's what to know.

Dopamine Fasting .....continue to page 27



Dopamine and the Brain

From the prefrontal cortex — your brain's control center — to the nucleus accumbens and ventral tegmental area located deep in your limbic system, dopamine bridges gaps between neurons to deliver critical messages about pleasure, reward, and motivation.

We all have a baseline level of dopamine. Substances and behaviors we like — everything from chocolate and sex to cocaine and amphetamines — increase dopamine firing.

"When we seek healthy rewards, like a good meal out in a restaurant or having a nice chat with friends, dopaminergic neurons fire, and dopamine is released," said Birgitta Dresp, PhD, a cognitive psychologist and research director with the Centre National de la Recherche Scientifique in Paris. "That gives us a good feeling."

But over time, with chronic exposure to hyperpleasurable stimuli, your brain adapts. Dopamine receptors downregulate and shrink, and your "hedonic setpoint," or baseline happiness level, drops. You now need more of your favorite stimuli to feel as good as you did before.

This primitive brain wiring served evolutionary purposes, helping our ancestors relentlessly pursue scarce resources like food. But in our modern world full of easily accessible, novel, potent, and stimulating activities, our brains are constantly trying to compensate. Paradoxically, this constant "self-titillation" may be contributing to our national and global mental health crisis, Lembke suggested.

"Human activity has changed the world we live in," said Lembke, "and now this ancient mechanistic structure has become a liability of sorts."

The Dopamine Fast in Action

To reset this wiring, Lembke recommends a 4-week fast from a person's "drug of choice." But this isn't the trendy tech-bro quick cure-all where you abstain from everything that brings you joy. It's a targeted intervention usually aimed at one behavior or substance at a time. The fast allows a person to understand "the nature of the hijacked brain," and breaking free motivates them to change habits long term, said Lembke.

Although the first 2 weeks are difficult, she finds that many patients feel better and more motivated after 4 weeks.

How do you identify patients who might benefit from a dopamine fast? Start with "how much" and proceed to "why." Instead of asking how much of a substance or behavior they indulge in per week, which can be inaccurate, Lembke uses a "timeline follow-back" technique — how much yesterday, the day before that, and so on. This can lead to an "aha" moment when they see the week's true total, she told the ACLM conference.

She also explores why they do it. Often patients say they are self-medicating or that the substance helps with their anxiety or depression. When people are compulsively continuing to use despite negative consequences, she might recommend a 4-week reset.

Important exceptions: Lembke does not recommend dopamine fasting to anyone who has repeatedly and unsuccessfully tried to quit a drug on their own nor anyone for whom withdrawal is life-threatening.

For people who can safely try the dopamine fast, she recommends "self-binding" strategies to help them stay the course. Consider the people, places, and things that encourage you to use, and try to avoid them. For example, delete your social media apps if you're trying to detox from social media. Put physical distance between you and your phone. For foods and substances, keep them out of the house.

Lembke also recommends "hormesis," painful but productive activities like exercise. Your brain's system for pleasure and pain are closely related, so these activities affect reward circuitry.

"You're intentionally doing things that are hard, which doesn't initially release dopamine, in contrast to intoxicants, but you get a gradual increase that remains elevated even after that activity is stopped, which is a nice way to get dopamine indirectly," she said.

If patients plan to resume their "drug of choice" after the dopamine fast, Lembke helps them plan how much they will consume and when. For some, this works. Others, unfortunately, go back to using as much or more than they did before. But in many cases, she said, patients feel better and find that their "drug of choice" wasn't serving them as well as they thought.

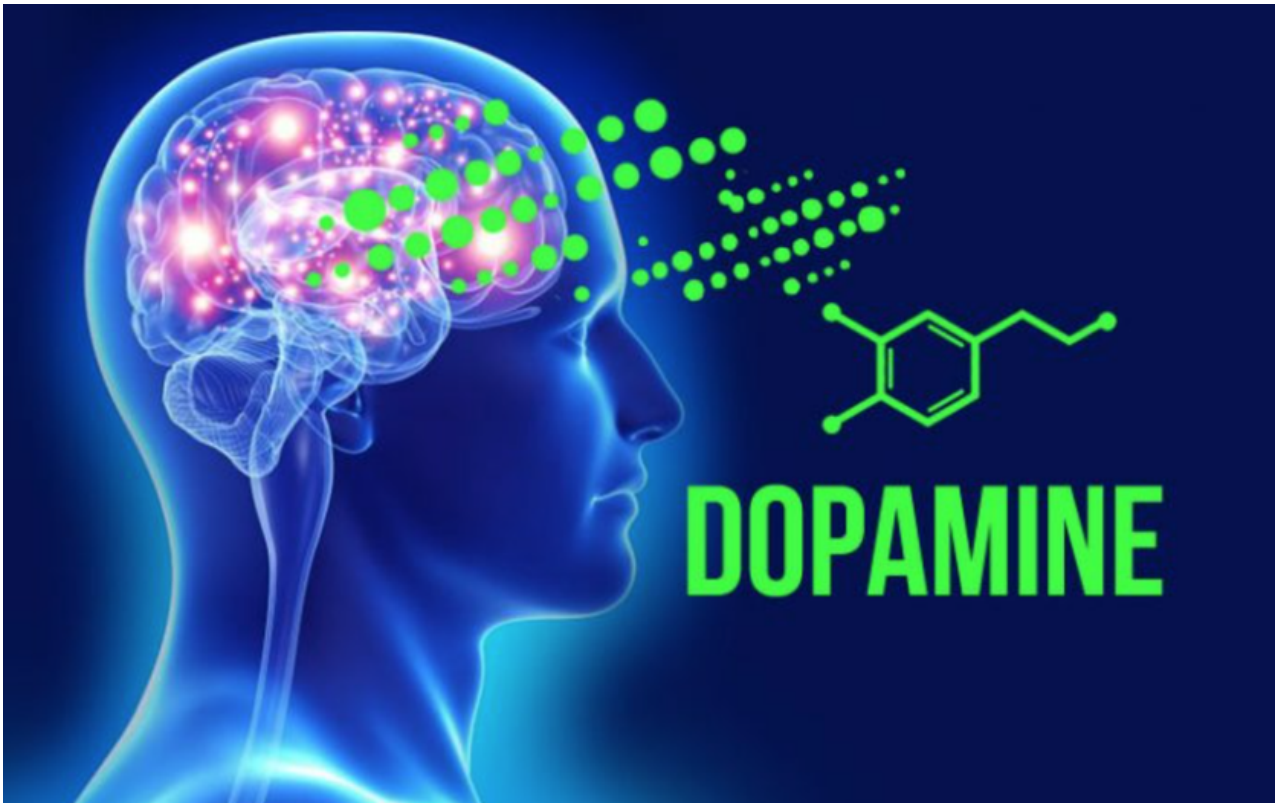
Critiques of Dopamine Fasting

Dopamine fasting isn't for everyone, and experts debate its safety and effectiveness. Here are some common concerns:

- I**t's too simplistic.** Peter Grinspoon, MD, a primary care physician at Massachusetts General Hospital and instructor at Harvard Medical School, said dopamine fasting isn't really fasting — you don't have a finite store of dopamine to conserve or deplete in a fixed amount of time. Even if you abstain from certain pleasures, your brain will still produce some dopamine.

- **What makes more sense,** he said, is gradual "dopamine retargeting," seeking rewards from healthy pleasurable activities.

- **"Addiction is a disease of isolation,** and learning to take pleasure in the healthy things in life, like a nice home-cooked meal or a walk in the woods or a hug or a swim in the ocean, is exactly what addiction recovery is about," he said. "Because once you learn to do that and to be happy, there's no longer any room for the drug and you're not nearly as susceptible to relapse."



- **A related concern is that the dopamine system isn't the only part of your brain that matters in addiction**. "There are other bits of the brain which are much more important for controlling temptation," said Trevor W. Robbins, PhD, professor of cognitive neuroscience and director of research at the Behavioural and Clinical Neuroscience Institute at the University of Cambridge. Dopamine plays an important role in addiction and recovery, "but to call this a dopamine fast, it's just a trendy saying to make it sound exciting," he said.

- **Empirical evidence is lacking.** Without clinical trials to back it up, dopamine fasting lacks evidence on safety and effectiveness, said David Tzall, PsyD, a psychologist practicing in Brooklyn. "It sounds kind of fun, right? To think like, oh, I'll just stop doing this for a while, and my body will correct itself," said Tzall. "I think that's a very dangerous thing because we don't have enough evidence on it to think of how it can be effective or how it can be dangerous."

- **Lembke "would like to see more evidence, too,"** beyond clinical observation and expert consensus. Future research could also reveal who is most likely to benefit and how long the fast should last for maximum benefit.

- **It's too much a one-size-fits-all approach.** "Stopping a drug of choice is going to look different for a lot of people," said Tzall. Some people can quit smoking cold turkey; others need to phase it out. Some need nicotine patches; some don't. Some can do it alone; others need help.

The individual's why behind addiction is also crucial. Without their drug or habit, can they "cope with the stressors of life?" Tzall asked. They may need new strategies. And if they quit before they are ready and fail, they could end up feeling even worse than they did before.

Experts do agree on one thing: We can do more to help people who are struggling. "It's very good that people are having discussions around tempering consumption because we clearly have a serious drug and alcohol addiction, obesity, and digital media problem," said Lembke.

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From Left : Mr Craig Pike, Mr Bethram Nkosi, Dr Tony Behrman, Mr Deryck Pike

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DISPENSING LICENSES CHANGING / ACQUIRING

The functioning of the licensing unit had been impeded from early 2018 when many DoH staff members refused to go to work in the Civitas Building in Pretoria.

Three out of seven staff members, including the head of the Unit, continued working, but the sheer volume of work (license and permit applications, license amendments, applications for designation, pharmacy license applications, Yellow Fever license applications), already then led to delays in processing and paperwork being misplaced and lost.

The only effective way of handing in paperwork, was to drive to the Civitas building, ask a member of the Licensing Unit to come down to reception and to have them sign receipt of license applications.

It was near impossible to get through on the phone lines of the Licensing Unit of the Department of Health. Covis 19 lockdown exacerbated this situation with staff members being sent home and only one email address being used to receive and process applications. This address was not published on their website or made known to the doctors, dentists, specialists, and registered nurses who at that time needed to either apply for or amend a dispensing license. Also, the head office (Civitas Building) was closed, so applications could also not be couriered. Obviously, it was also impossible to contact the Unit via telephone.
As a medical practitioner practising in Cape Town, it would have been extremely difficult to amend a dispensing license due to the issues mentioned above.

The fact that you already have a license, but need to amend it, however, means that:

- You had complied with the Medicines and Related Substances Act, Act 101 of 1965, as amended (Sections 22C and 22A), in that you completed a supplementary course in dispensing.
- Successfully applied for a license.
- Needed to amend this license, but various factors at the DoH and the lockdown, made it virtually impossible for you to do so.

Against this background and seen in the context of the ethical principles of inter alia, maleficence and non-maleficence, medical practitioners throughout the country had to choose between complying with an administrative requirement OR providing essential and in some cases life-saving medicines during a pandemic.

DD van Zyl
Director: Focus on Health

Please see page 32 for further information regarding problems with the building used by the Department of Health dating back to 2018 and which are still current.

Dispensing Licenses .....continue to page 32

Health department head office in ,Civitas building a hazard for staff.

"November 5, 2018"

The Citizen reports that the Department of Health (DOH) is planning to appeal the prohibition notice that led to its Pretoria head office being shut for being "unsafe and unhealthy".

For the past seven months, the DOH's staff have refused going to work in the 29-storey Civitas Building in the Pretoria CBD, saying the property, which also houses Health Minister Aaron Motsoaledi's office, was not health-compliant. Workers complained of constant headaches, shortness of breath and severe sinusitis because "the building had no windows, had poor air circulation and dirty carpets". They also claimed its fire-fighting systems malfunctioned. Following an assessment, the Department of Labour's (DOL's) inspector-general last Thursday declared Civitas Building, which is leased by the Department of Public Works, noncompliant. This was after the Labour Court referred the department and its employees to the DOL last month, stating that it did not have jurisdiction over the matter. Staff, including members of National Education, Health and Allied Workers' Union (Nehawu) and the Public Servants Association, celebrated their victory outside the building on Tuesday. The DOH's deputy director-general for corporate services Valerie Rennie said they would notify staff when they could return to work.

Outdated tobacco law threatens progress towards smoke-free South Africa, says Philip Morris

The bill prevents the access of South African smokers to scientifically substantiated products which are an alternative to smoking cigarettes.

The proposed Control of Tobacco Products and Electronic Delivery Systems Bill approved by Cabinet last year is a lost opportunity to make adult smokers aware of smoke-free alternatives, says Philip Morris South Africa (PMSA).

“The Control of Tobacco Products and Electronic Delivery Systems Bill which has been on the agenda since 2018, if passed in its current form, misses a huge opportunity to encourage all adult South Africans who would otherwise continue smoking to switch to smoke-free alternatives,” says Branislav Bibic, Managing Director at Philip Morris South Africa.

He stresses that it also undermines the efforts of adult smokers who have switched to better alternatives, such as heated tobacco products and e-cigarettes as an alternative to continued smoking.

“While we support the government’s intentions to combat tobacco prevalence and youth uptake in South Africa, we would welcome a discussion with regulators on how to best facilitate suitable access to these products within a reasonable regulatory framework at this time,” he adds. “We need the right regulatory framework, encouragement, support from civil society, and the full embrace of science before any decisions are made.”

He explains that the proposed Control of Tobacco Products and Electronic Delivery Systems Bill should provide the country with an opportunity to make this a possibility by differentiating the way in which scientifically substantiated products that don’t burn tobacco are regulated differently compared to cigarettes.

The Citizen 23 Jan 2024

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SOCIETY HAS A RIGHT TO TOBACCO HARM REDUCTION INITIATIVES: 15 YEARS AND THE NEEDLE HAS NOT MOVED - DR KGOSI LETLAPE

Panama will play host to the tenth World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) Conference of the Parties (COP), where decisions on tobacco control will be taken that may have far-reaching implications for the world's more than a billion smokers.

"It is time the WHO became courageous and reliant on science and truth to engage all who have a stake in preventing 8-million deaths per annum and ultimately more needs to be done by the World Health Organisation's Framework Convention on Tobacco Control," says Dr Kgosi Letlape, harm reduction advocate. "All should be in the room when our fate is discussed by the politicians and democrats at the WHO."

The Africa Harm Reduction Alliance says that this year marks the 20th anniversary of the FCTC adopted by the WHO and yet Dr Letlape says that still the significant positive impact that tobacco harm reduction can have on public health is not being acknowledged.

It is sad to note Dr Letlape says that in South Africa on recommendations of the WHO, people who smoke are being criminalised in the new proposed bill.

He continues: "Our homes are being turned into crime scenes in respect to the proposed bill.Our authorities have adopted a quit or die approach where in their preamble they talk about quitting and don't accept the reality that globally 1.3 billion people continue to smoke."

"Smokers need technology and science to help them and our government needs to realise that people need access to knowledge and access to these products with full knowledge of the harms associated.Tobacco harm reduction is a life saver, we only need to look at Sweden to see how it works," he says.

The system works, Dr Letlape adds, the FCTC has played a major role in reducing prevalence of tobacco use with a 15-20 percent reduction but over the last 15 years the needle has not moved.

"Countries that have embraced harm reduction like Sweden that have combined the FCTC and tobacco harm reduction initiatives have been able to reduce tobacco use towards the end goal of 5 percent tobacco use," he explains.

He says that there is a clear indication of the reduction of embracing non-combustible tobacco. "Sweden started 2023 at 4.7 percent and towards the end of the year, tobacco use will be at 5 percent," he adds.

As it stands nicotine use in Sweden is in the high teens just like in other European countries but combustible tobacco as a component of nicotine use is now approaching 5 percent and less."

It is important to note however, adds Dr Letlape, that when the FCTC was adopted in 2003, the only non-combustible form of tobacco was oral tobacco and since 1973 the Swedes have put loose oral tobacco into a sachet and called it Snus.

"Regrettably the WHO recommended the banning of Snus and the Swedes had to fight to get an exemption from the WHO which was granted and hence their success."

According to the Global Health Report, if other European countries allowed the use of non-combustible tobacco like Snus, over 350-thousand deaths could be prevented per annum. "Sweden has seen this incredible achievement despite public health protests and despite recommendations by WHO that snus be banned," he says.

Society Has a Right to Tobacco .....continue to page 37

Now is the time, says Dr Letlape, “the FCTC cannot be used to force consumers to use combustibles - let this be a mnemonic for the FCTC.”

“As a physician, I acknowledge and accept that the primary advance to people who smoke and are dependent on nicotine is to quit,” he explains.

“While the FCTC promotes access to cessation clinics, unfortunately most health systems where the majority of smokers live cannot access these clinics directly, impacting vulnerable groups.”

With no access to cessation, clinics or tobacco harm reduction policies, the cheapest way to get a nicotine fix is via a cigarette Dr Letlape adds: “This needs to change to move the needle, if it doesn’t nothing will change, people will continue to smoke.”

“We acknowledge that there are 1 billion to 1.3 billion people who continue to smoke despite knowing the dangers,” he adds. “The approach of quit or die is not helpful and for me it is unethical to say this when there are less harmful alternatives available – we have an ethical duty to make them available and it is an ethical duty for the WHO to make regulators take note.”

80% of the world’s 1 billion smokers live in LMIC’s, where the WHO FCTC has managed to convince governments to ban less harmful alternatives or regulate so strictly that smokers are sceptical about their harm reduction potential.

We see this in India, Vietnam, Argentina, Brazil, and Panama where the WHO FCTC COP 10 is taking place. In the developed world, the opposite is happening.

African countries need to look at the science behind these innovative products and create their own regulations for their populations, the developed world is using tobacco harm reduction to reduce smoking rates faster than countries who do the opposite. Harm reduction is not only for the developed world.

Article 1D of the FCTC clearly states: “tobacco control” means a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke;”

Notably, Dr Letlape says, it has only been since 2015 that there are other viable alternatives like e-cigarettes, heat not burn products and lately since 2017 nicotine pouches available. “We therefore cannot use a framework for combustibles to regulate non combustibles,” he stresses. “Regulation is essential, and it is disappointing that the WHO chooses not to lead and mislead nations in this respect.”

The other matter that he says needs serious attention is article 5.3 which has been misrepresented and needs to be revisited. “Excluding others from the Conference of the Parties in the tobacco control debate, like the tobacco industry, NGOs and people who smoke is problematic,” he adds. “Solving any of the world’s problems that society is faced with should include debate from both the perpetrators and the victims to be part of the discussions to find solutions - take climate change for example, petroleum companies could not be excluded from the debate, how is this any different?”

He points out that It is high time that COP becomes inclusive and stops behaving like kings and telling us what to do as society. “We all have a stake and as a humble South African I have learnt from Madiba that if you need to find lasting solutions you have to engage the enemy, that is why Madiba led us to engage in discussions with our oppressors to find a peace we still seek,” he adds.

“The time has come to involve people who smoke, like my father and my descendants and those of us who are passive smokers and who live with it,” he says. “All of us have a right to proper knowledge and access to less harmful products and the industry, NGO’s, people who smoke actively and passively, should be in the room when our fate is discussed by the politicians and democrats at the WHO.”

Regulation needs to be based on science and proof and not ideology, Dr Letlape explains. “I am not advocating for the industry or politicians to be trusted but we need to engage with each other to find meaningful solutions.”

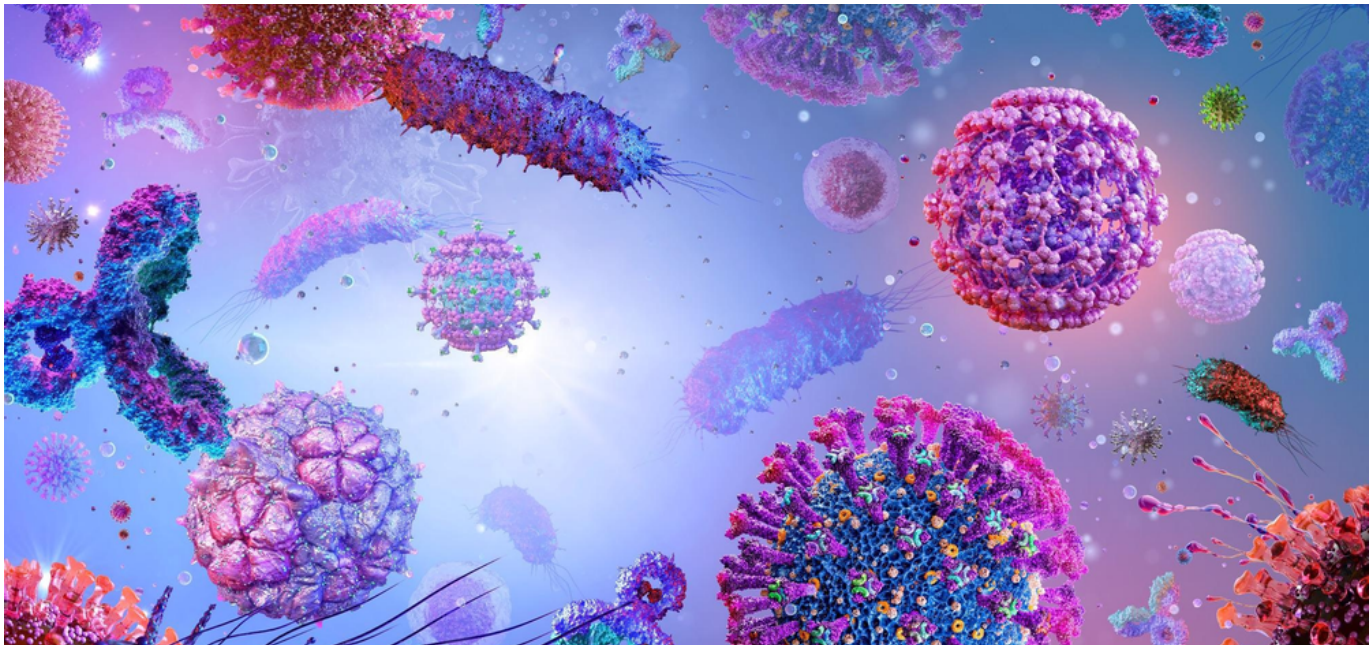
He says that we see examples of other nations that accept harm reduction in a variety of forms: In the UK they embrace e-cigs but ban Snus. In Japan they embrace heated tobacco and both countries as the uptake of risk reduced products increases, they see a simultaneous use of cigarette decline and they see a decline of nicotine use. Contrary to what has been said he adds, the data shows they are not a gateway to combustible but a gateway to reduce the prevalence of combustible use.

“It's time to hold the WHO accountable for the continuing deaths of people who smoke and we need to demand a safe space for dialogue,” he adds. “Scientists on different sides must be prepared to engage each other civilly, and allow the evidence to reign.”

He notes that policies should be based on what we know and what the science says, not on our fears or what we think we know. He says that this research should be funded by governments as it is their duty to refute the claims of the industry.

“Those pedalling misinformation against science should be regulated and there should be more accountability of what people put out there,” says Dr Letlape. “I subscribe to the motto of patient organisation: nothing for us without us and with this in mind we are asking to be included in future COPs, starting with the one in Panama this year and industry has a right to be at those discussions alongside MPOs and NGOs who have an interest in the wellbeing of people who smoke.”

RESPIRATORY VIRUS SURGE: DIAGNOSING COVID-19 VS RSV, FLU



January 25, 2024 – Amid the current wave of winter respiratory virus cases, influenza (types A and B) leads the way with the highest number of emergency room visits, followed closely by COVID-19, thanks to the JN.1 variant, and respiratory syncytial virus (RSV). With various similarities and differences in disease presentations, how challenging is it for physician's to distinguish between, diagnose, and treat COVID-19 vs RSV and influenza?

While these three respiratory viruses often have similar presentations, you may often find that patients with COVID-19 experience more fever, dry cough, and labored breathing, according to Cyrus Munguti, MD, assistant professor of medicine at KU Medical Center and hospitalist at Wesley Medical Center, Wichita, Kansas.

"COVID-19 patients tend to have trouble breathing because the alveoli are affected and get inflammation and fluid accumulating in the lungs, and they end up having little to no oxygen," said Munguti. "When we check their vital signs, patients with COVID tend to have hypoxemia [meaning saturations are less than 88% or 90% depending on the guidelines you follow]."

Patients with RSV and influenza tend to have more upper respiratory symptoms, like runny nose, sternutation — which later can progress to a cough in the upper airways, Munguti said. Unlike with COVID-19, patients with RSV and influenza — generally until they are very sick — often do not experience hypoxemia.

Inflammation in the airways can form as a result of all three viruses. Furthermore, bacteria that live in these airways could lead to a secondary bacterial infection in the upper respiratory and lower respiratory tracts — which could then cause pneumonia, Munguti said.

Long COVID .....continue to page 39

Another note: Changes in COVID-19 variants over the years have made it increasingly difficult to differentiate COVID-19 symptoms from those of RSV and influenza, according to Panagis Galiatsatos, MD, pulmonologist and associate professor at Johns Hopkins Medicine. "The Alpha through Delta variants really were a lot more lung tissue invading," Galiatsatos said. "With the COVID-19 Omicron family — its capabilities are similar to what flu and RSV have done over the years. It's more airway-invading."

It's critical to understand that diagnosing these diseases based on symptoms alone can be quite fickle, according to Galiatsatos. Objective tests, either at home or in a laboratory, are preferred. This is largely because disease presentation can depend on the host factor that the virus enters into, said Galiatsatos. For example, virus symptoms may look different for a patient with asthma and for someone with heart disease.

With children being among the most vulnerable for severe respiratory illness, testing and treatment are paramount and can be quite accurate in seasons where respiratory viruses thrive, according to Stan Spinner, MD, chief medical officer at Texas Children's Pediatrics and Urgent Care. "When individuals are tested for either of these conditions when the prevalence in the community is low, we tend to see false positive results."

Texas Children's Pediatrics and Urgent Care's 12 sites offer COVID-19 and influenza antigen tests that have results ready in around 10 minutes. RSV testing, on the other hand, is limited to around half of the Texas Children's Pediatrics and none of the urgent care locations, as the test can only be administered through a nasal swab conducted by a physician. As there is no specific treatment or therapy for RSV, the benefits of RSV testing can actually be quite low — often leading to frustrated parents regarding next steps after diagnosis.

"There are a number of respiratory viruses that may present with similar symptoms as RSV, and some of these viruses may even lead to much of the same adverse outcomes as the RSV virus," Galiatsatos said. "Consequently, our physicians need to help parents understand this and give them guidance as to when to seek medical attention for worsening symptoms."

There are two new RSV immunizations to treat certain demographics of patients, Spinner added. One is an RSV vaccine for infants under 8 months old, though there is limited supply. There is also an RSV vaccine available for pregnant women (between 32 and 36 weeks gestation) that has proven to be effective in fending off RSV infections in newborns up to 6 months old.

Physicians should remain diligent in stressing to patients that vaccinations against COVID-19 and influenza play a key role in keeping their families safe during seasons of staggering respiratory infections.
"These vaccines are extremely safe, and while they may not always prevent infection, these vaccines are extremely effective in preventing more serious consequences, such as hospitalization or death," Galiatsatos said.

ASSISTED DEATH: 'I'VE LOST THE WILL TO LIVE'

To find a copy of a "Living Will" please have a look at PRACTICE MANAGEMENT on www.docweb.co.za

GEORGE NEWS - Carol de Swardt, a George resident who has been in the news for her decision to go to Pegasos Clinic in Switzerland for assisted death, says she has no fear for what is awaiting her at the end of the month.

"I have peace in my heart. I really hope that my God is there on the other side. I do not think my God would refuse me my place in heaven. I have lost my will to live," De Swardt (63) told George Herald.

De Swardt, once a lively woman who loved the outdoors and adventure, is living in debilitating pain due to skin cancer that was diagnosed in 2010 and which has since spread.

She is also disabled after one leg had to be amputated as a result of what later seemed to be excessive radiation treatment she had received in a state hospital in KwaZulu-Natal.

After a lengthy legal battle, the High Court in Pietermaritzburg ordered the Health Department in 2020 to pay her more than R4m in compensation for damages. She is using some of that money to pay for her assisted death.

On Tuesday 23 January, De Swardt (63) said she just wants to spend the last few days before leaving with her family after being inundated by media interviews.

Her son, Donovan, and daughter, who wishes to remain anonymous, have accepted her decision. Both are with her at her home in Heather Park where she has been living for the last three years since moving to George.

ASSISTED DEATH .....continue to page 41

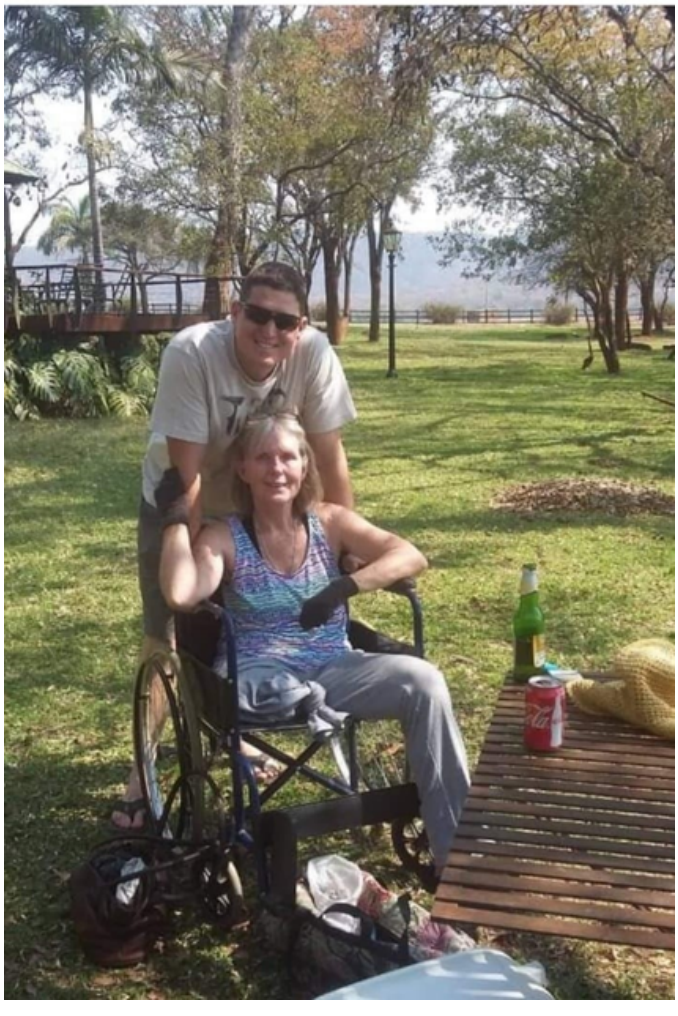
De Swardt said there is no reason for her to live anymore because she has no quality of life.

"If I lived longer, I would want to do all the things I used to, that I loved, but I am disabled. All these things were taken from me - fishing, swimming, and working in my garden."

Asked if she has forgiven the medical team responsible for the radiation treatment, she said, "I do feel a bit of resentment, but it will not undo what they did. It will not bring my life back. I lost it when I lost my leg. A grudge will not bring it back, so I do not hold any hatred in my heart. What upset me was that they lied about it and said they did not do anything wrong, when they did."

She has many precious memories of her life. "Some really stand out. Camping with my two children in Kelso and camping in Transkei are two memories that forever stay with me. It was no ordinary camping in Kelso. I was a single mom and we would go with a railway tarpaulin we retrieved which had been blown off a train onto the tracks. We would build our camp over a tree branch and my car and make our camp really cosy and spend the weekend by the sea with people playing bongo drums in the camp.

Love you mom. The way you have dealt with this trauma has been an inspiration.



"My kids had fun and so did I. In Transkei we went for three weeks to camp on the beach. No time, no radio, no phone calls. Just us and the beach and sea. We fished for our food and time stood still for a while."

De Swardt will be assisted by Prof Sean Davison* who oversees the Exit Swiss Assistance Programme. She is leaving for Switzerland on Sunday 28 January and her day of death is 31 January.

- Prof Sean Davison, New Zealand-born South African scientist, is the founder and director of DignitySA that is lobbying for a change to end-of-life legislation in South Africa. He was under house arrest for three years after being convicted in 2019 on three counts of premeditated murder for helping three men to die.

gems Corner

TO REGISTER/ACTIVATE YOUR BANK DETAILS YOU WILL NEED TO PROVIDE FUNDERS WITH THE FOLLOWING INFORMATION TO ENSURE A SEAMLESS PROCESS.

- Signed practice letterhead must include the practice number. If more than one partner/ incorporator or directors, all parties must sign the letterhead. Practice address must reflect on the signed letterhead.
- Certified copies of ID/s of all partners, close corporation, incorporator, and directors.
- Bank letter or statement not dated older than 3 months.
- CIPC documentation. (Partnership, Close Corporation, Incorporation, Company, and Association)
- Proof of practice address not older than 3 months. Utility, lease agreement and or rental invoice.
- If doctor works from hospital and cannot provide proof of address , they require a confirmation letter on a hospital letterhead signed by the hospital manager confirming sessional rooms.
- If the account name differs from practice name a “Trading As” letter is required.
- BHF confirmation form
- If the practice is administered by a bureau, the Doctor must sign consent on all information to be updated/ changed.
- If the bank account name is in the name of a bureau, all relevant information from the bureau must be sent to update practice details.
- If the Doctor’s surname differs from the practice name, a marriage certificate may be required (if applicable).

We will endeavour to respond to your request within 3 to 5 working days on receipt of your request.

You can email to implemenation@mhg.co.za or fax (021) 4805087 or call our hunt line on (021) 4804753.

GEMS: IMPLEMENTATION DEPARTMENT

GEMS Corner .....continue to page 43

gems Corner

Government Employees Medical Scheme

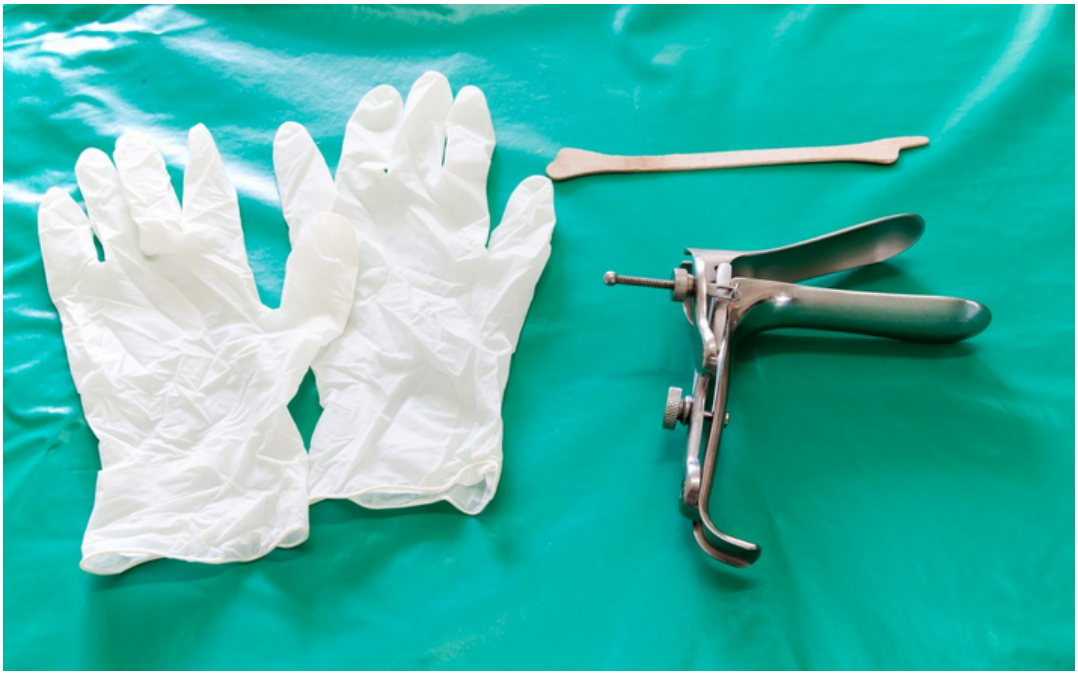
BREAKING NEWS

After extensive discussion with CPC/Qualicare , GEMS has agreed to an **enhanced** PAP smear fee consisting of :

- A full consultation Code 0191 plus
- A fee for a sterile tray and specimen handling fee, Code 99385 as reflected in the table below.

Updates on fees chargeable for Pap smear plus a consultation 0191

Contracted (Discipline 14/15)	Non-contracted(Discipline 14/15)
2024 Tariff value: (Code 99385) R241.30	2024 Tariff value: (Code 99385) R217.30



GEMS Corner .....continue to page 44

gems Corner

Government Employees Medical Scheme

GEMS Payment Runs

Belinda Madengwane

Recommended
Ms Belinda Madengwane

Recommended
Ms Karyna Van Lingen

Dr Stan Moloabi (Nov 14, 2023 08:04 GMT+2)

Approved
Dr BOS Moloabi

Discovery CORNER

• Allocated consultant for Qualicare sent me the following note about the current DH 'Smart Plan' issue:

DH Problem: 'Smart Plan Intermittent rejections'

We are aware of the following issue affecting Smart Plan claims:

- We are aware that claims for GP consultations are not funding and incorrectly applying reason code 198 when billed by a GP (practice types 014, 015 or 050).
- Reason code description: You reached the Above Threshold Benefit limit. We will not pay further out of hospital claims.
- Please note we are still investigating this issue and I will share more information when received.

In the meantime, I can assure you that the impacted claims will be reprocessed through a bulk rework once this issue is resolved.

Kindly accept our sincerest apologies for the inconvenience caused.

Discovery Corner .....continue to page 46

Discovery CORNER

Keycare Updates

Overview:

The Keycare plan has approximately 460 000 members.

Medical evidence supports the understanding that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP.

Keycare members that visit their Primary GP only have an 8% lower admission rate.

Updates in 2024:

In alignment with achieving improved health outcomes, ensuring efficient healthcare referral pathways and improved healthcare coordination, the following benefit changes will be implemented across the KeyCare Series from 1 January 2024:

- Primary GP nomination: To align with the Scheme's single care coordination strategy, KeyCare Plus members will no longer have cover for secondary GP consultations, with all day-to-day healthcare needs being addressed and coordinated by one nominated primary GP.
- Out of network consultations: Similarly, out-of-network GP consultations for KeyCare Plus, KeyCare Start and KeyCare Start Regional members will be replaced with one annual consultation with a network nurse or healthcare provider at a network pharmacy clinic.

Members will be referred for a virtual consultation with a GP or an in-person consultation where needed.

- Changing a nominated GP: KeyCare members have the option to change their nominated GP three times per year, after which approval is needed.

Hospital Network Changes

There have been changes made to the KeyCare Hospital Network.

The following procedures will be added to KeyCare exclusion list:

- Tonsillectomies
- Myringotomies
- Adenoidectomies

Cover will be provided in emergencies or when PMB treatment is required

POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Network GP Nomination form

Please note that by choosing a GP that's within a network prevents unnecessary use of your benefits and repeat of tests. Kindly note that both the main member and the beneficiaries are encouraged to nominate their own network GP.

Please complete all sections on this form using block letters.

Please return your completed form to us via one of the following methods:
- Email: Polmedgpnomination@medscheme.co.za
- Fax: 0861 728 722
- Walk-in branch: Hand deliver it to your nearest Polmed branch
- Post: Private Bag X16, Arcadia 0007

Section 1: Principal Member's Contact Details:

Membership Number:

Name & Surname:

Rank:

ID Number:

Postal Address:

Code:

Physical Address:

Code:

Telephone Home: Telephone Work:

Cellphone Number: Fax:

E Mail address:

Section 2: Current Network GP Details:

Please complete all sections on this form and complete your details using block letters.

	Name & Surname	ID Number	Doctor's name	Practice number	Dependant's Email Address/ Mobile number	Dependant's Physical Address
Main Member						
Dependant 1						
Dependant 2						
Dependant 3						
Dependant 4						
Dependant 5						
Dependant 6						

Medscheme Corner .....continue to page 48

POLMED
OUR INVESTMENT OUR HEALTH OUR FUTURE

Network GP Nomination form

Section 3: Change your GP

I request that my nominated GP be amended as indicated below:

Please complete this section if you would like to change your current nominated network GP. *Only the main member is allowed to nominate 2 Network GP's

Please complete all sections on this form and complete your details using block letters.

	Name & Surname	ID Number	Doctor's name	Practice number	Doctor's Email Address/ Telephone Number
Main member					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

Member's signature _____ Date D D M M Y Y Y Y

Medscheme CORNER

BOTH DOCTORS AND PATIENTS SUFFER POOR OUTCOMES WHEN THE STATS ARE CONFUSED .

Here follows a shortened summary of the circus that went on to try to correct an Polmed REPI report based on statistical parameters over which the doctor had no control.

History of the complaint:

A practice which closely studies the REPI report(s) & tries to comply as to stay on Repi 1 contacted us to say that they did not receive any POLMED Repi Report during 2023.

The REPI 2022 reports indicate that according to this report they are on REPI 1, BUT for 2023 , they are only been paid REPI 2 fees?

They have never received a report that says that they have been downgraded to REPI 2??

Eventually, after multiple calls by our QCC staff , they were supplied with an more recent REPI report which stated that they had been down graded due to low numbers of attributed patient in the past 12 months, despite have scored excellent values in 3 parameters on REPI.

How on earth is a doctor supposed to control low numbers of attributed patients, or that female patients prefer to have their Cervical smears done at a female general practice ?

Medscheme CORNER

Q: Polmed Tariff code 55500 Polmed Consultation for GP's Annual medical – Preventative Care benefits
A: How many of the 'procedures' must be done during such a visit?

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

Polmed Nominations Forms :
Q: GP nominations for each patient. Who is supposed to give this form to the patient to fill out? What happened to the days where you consult with any patient and offer your best service and get paid accordingly? Not have to worry about whether you are nominated or not.
Moet al ons Polmed pasiente wat daarop gelys is dit nou invul? Wie betaal vir die dokter se tyd om dit te doen.
A: It is the members responsibility to complete and submit. Medscheme requires Membership details to look into each case

MEDSHIELD
medical scheme
CORNER

MEDSHIELD

Q: Participation fee question from a dispensing doctor is paid separately and when?

A: Please find below the breakdown:

Consultation Fee – Dispensing Provider = R363

Participation Fee of R157 which is included in the total amount of R520

Q: ***MEDSHIELD*** > Medscheme Relationship??

A: The Scheme receives Provider information from the BHF (Dispensing/Non Dispensing) via the Nexus Admin platform and loads as such-this dictates the way payment is made. The Provider should call the BHF to get this resolved and double check with the Medscheme Provider Call Centre as we (Medshield) use their administration system(Nexus)

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 53

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/

QualiCare

01 Jan 2023 - 31 Jan 2023

DOC Web www.docweb.co.za

docweb traffic

Reported period	Month Jan 2024				
First visit	01 Jan 2024 - 00:05				
Last visit	31 Jan 2024 - 22:53				
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	**1,204**	**1,803** (1.49 visits/visitor)	**6,208** (3.44 Pages/Visit)	**28,713** (15.92 Hits/Visit)	**4.08 GB** (2369.94 KB/Visit)
Not viewed traffic *			**23,373**	**36,385**	**6.42 GB**

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

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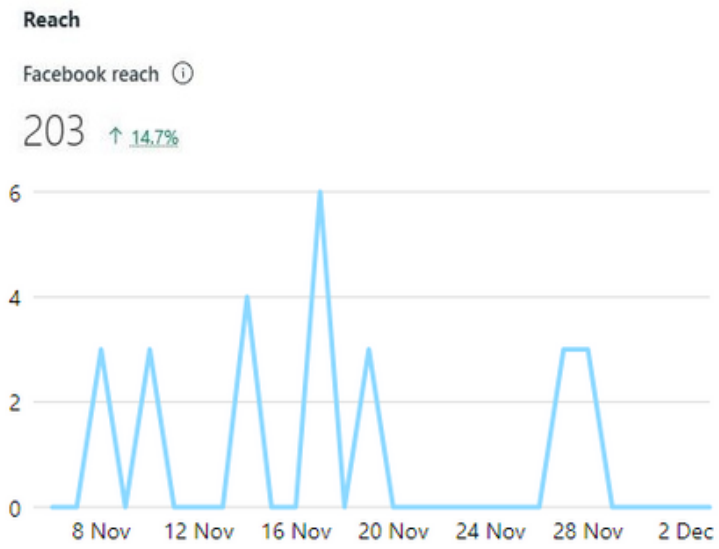
Facebook page overview

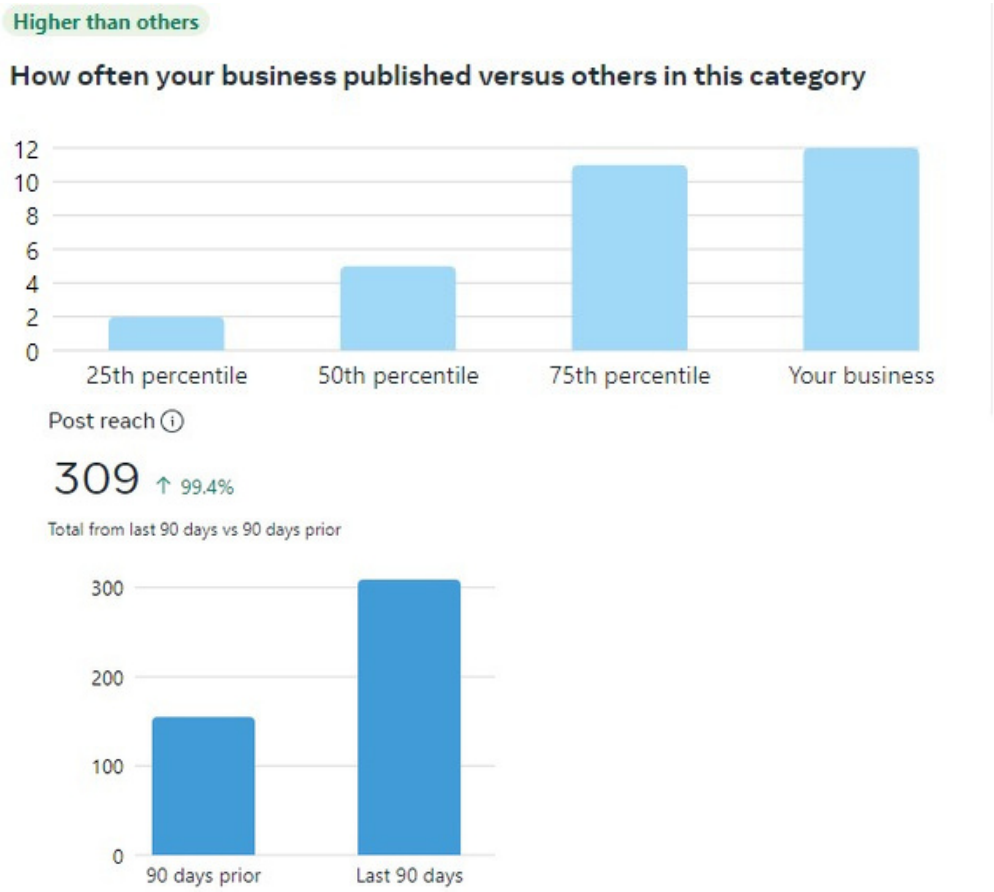
Last 28 days

Post reach
202

Post engagement
40



Published content



Disclaimer:

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

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

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